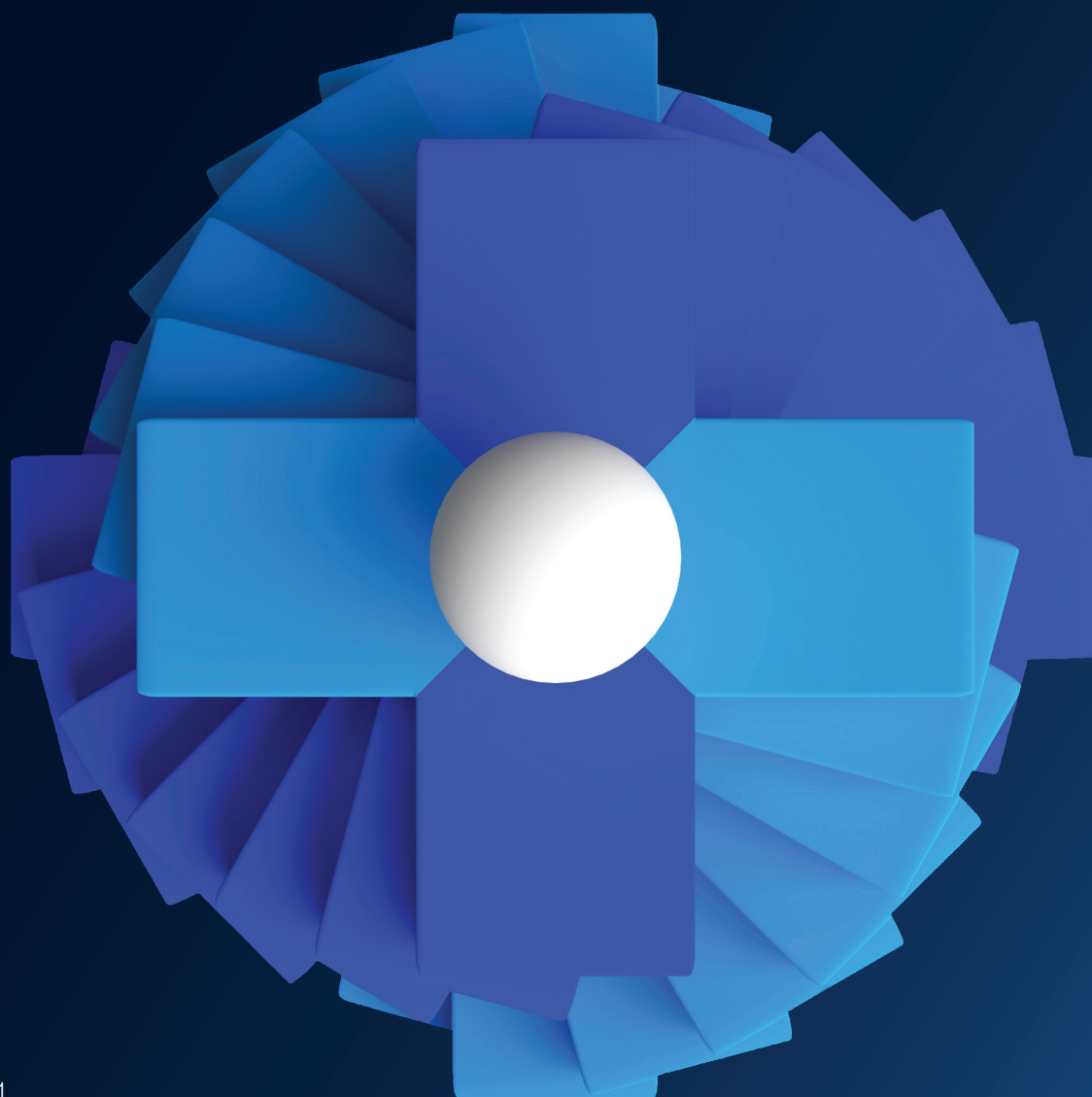


McKinsey Center for US Health System Reform

Administrative simplification: How to save a quarter-trillion dollars in US healthcare

Perspectives on the Productivity Imperative in US Healthcare Delivery





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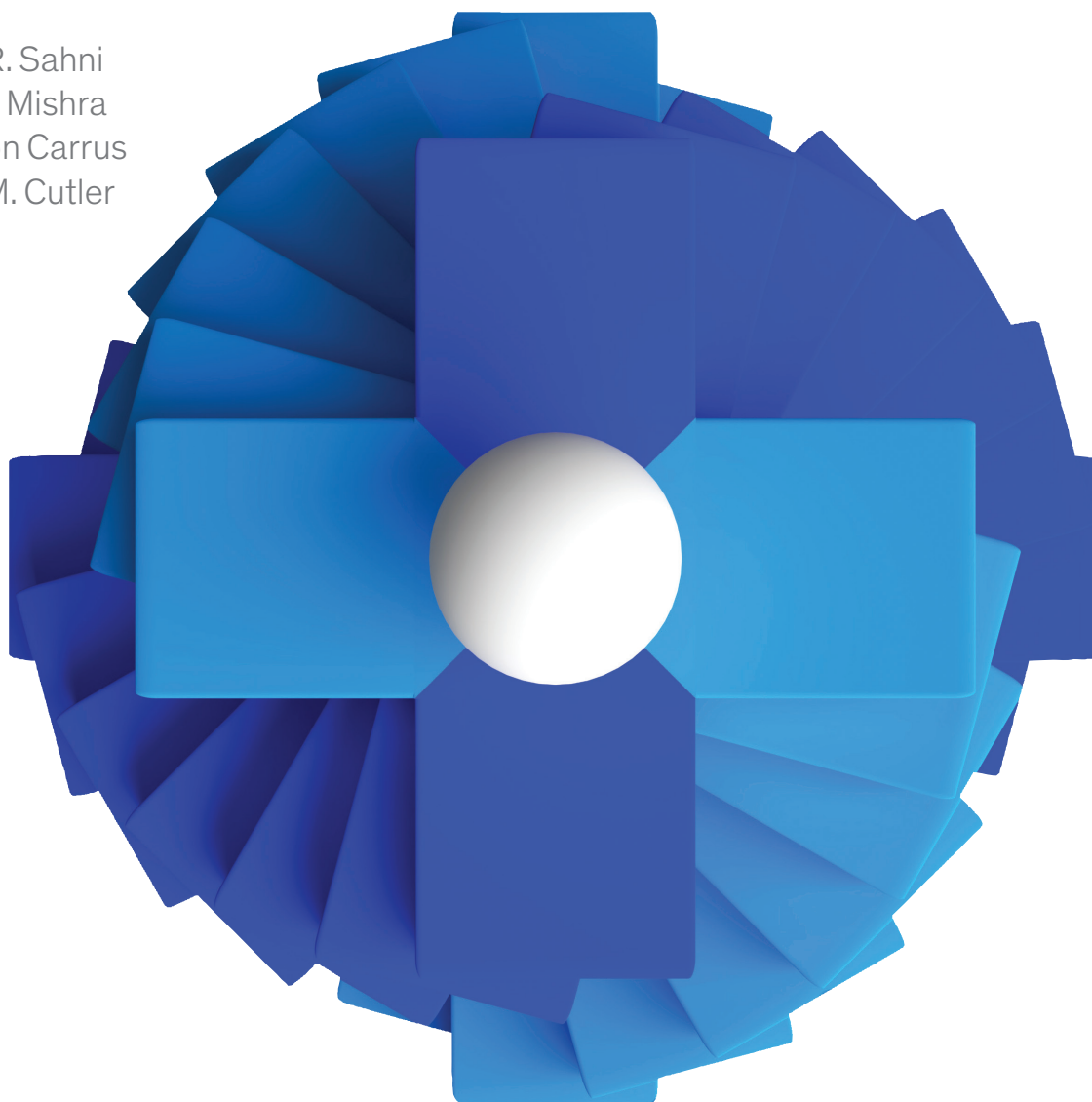
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October 2021

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Preface

This report, “Administrative simplification: How to save a quarter-trillion dollars in US healthcare,” lays out a roadmap for how to capture \$265 billion of administrative spending savings in healthcare. We built what we believe to be a first-of-its-kind bottom-up analysis of how to best allocate the \$950 billion of administrative spending in healthcare today to stakeholder groups such as private payers, hospitals, and physician groups. We translated each stakeholder group’s profit-and-loss (P&L) statement into functional focus areas, such as a financial transactions ecosystem and administrative clinical support functions, to align with about 30 known interventions that could drive these savings. The aim of this independent report, produced by the McKinsey Center for US Health System Reform, is to arm public and private sector leaders with fact-based insights to guide informed decision making.¹

This report continues a series of perspectives on the productivity imperative in US healthcare delivery. This effort began over a decade ago with an investigation of why healthcare spending was higher in the United States than in other wealthy countries.^{2,3} Following this, “The next imperatives for US healthcare” report laid out three steps the country could take to better control that spending: achieve rapid—and dramatic—productivity improvements in the delivery of health services, improve the functioning of healthcare markets, and improve population health.⁴ Most recently, “The productivity imperative for healthcare delivery in the United States” reframed the healthcare discussion from wasteful spending to improving productivity across labor, capital, and multifactor productivity.⁵

The research underlying this report was led by three McKinsey consultants—Nikhil R. Sahni, a partner; Prakriti Mishra, an associate partner; and Brandon Carrus, a senior partner—in conjunction with David M. Cutler, Otto Eckstein Professor of Applied Economics at Harvard University.⁶ Valuable perspectives and advice were offered by a distinguished panel of academic and industry experts, including Julia Adler-Milstein, Tanya Bentley, David Blumenthal, Melinda Buntin, Michael Chernew, Gaurov Dayal, Wendy Everett, William Frist, Ishani Ganguli, Elizabeth Goodman, Michelle Hood, Rob Huckman, Chip Kahn, Joe Kimura, Bob Kocher, Annie Lamont, Heather McComas, Sandhya Rao, Jaewon Ryu, Mario Schlosser, April Todd, Mike Vennera, and Wendy Warring.⁷

The report also benefited enormously from the contributions of McKinsey’s global network of industry experts. It drew on McKinsey’s in-depth analytical expertise, our work with leading healthcare organizations, and our understanding of healthcare systems around the world.

The authors would like to thank the external and internal advisers for their contributions, as well as Gary Chia, Julius Ewungkem, Nicolas Garcia, Brooke Istvan, Neda Bassir Kazeruni, Crosbie Marine, Chrissy Meder, Garam Noh, Rahi Punjabi, and Mara Reichle, who helped with analyses. In addition, the authors would like to thank Sharmeen Alam, Lyris Autran, Allan Gold, Ginny Hull, Elizabeth Newman, Sarah Smith, and Susan Schwartz for their help in editing, producing, and disseminating this report.

¹ This report was not commissioned or sponsored in any way by a business, government, or other institution.

² Diana Farrell, Eric Jensen, Bob Kocher, Nick Lovegrove, Fareed Melhem, Lenny Mendonca, and Beth Parish, “Accounting for the cost of US health care: A new look at why Americans spend more,” December 1, 2008, McKinsey.com.

³ Jesse Bradford, David Knott, Edward Levine, and Rodney Zimmel, “Accounting for the cost of US healthcare: Pre-reform trends and the impact of the recession,” December 2011, McKinsey.com.

⁴ Shubham Singhal and Erica Coe, “The next imperatives for US healthcare,” November 1, 2016, McKinsey.com.

⁵ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, “The productivity imperative for healthcare delivery in the United States,” February 27, 2019, McKinsey.com.

⁶ Nikhil Sahni is also a fellow in the Economics Department at Harvard University.

⁷ By reviewing this paper, no individual is endorsing its conclusions. All errors remain our own.

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Executive summary

Every organization or large-scale system needs a base of administrative functions to run. As these functions adopt new technologies and innovations, spending typically drops and quality improves. Consider payment processing, which is faster and cheaper than ever, or signing up for a new mortgage, for which you can get preliminary approval on your phone in minutes. Despite generations of technological advancements, however, the US healthcare system remains stuck: productivity and quality have stagnated, and change has been slow.¹

Of the nearly \$4 trillion spent on healthcare annually in the United States, administrative spending is about one-quarter of the total; delivery of care is about three-quarters. But what portion of that administrative spending is unnecessary, and how can it be simplified?

To answer these questions, it is critical to understand what is truly necessary spending. The US healthcare system, with thousands of hospitals and physician groups and more than 900 payers, is geared both to local service and to competition.² The predominant fee-for-service payment model puts competitive checks and balances on payers, hospitals, and physician groups. This leads to a number of benefits for the United States, such as being known as a world leader of innovative care delivery. But this fragmentation can also lead to unnecessary spending due to the number of communication and transaction points among all these organizations. For example, for a healthcare claim to be paid, it must go through multiple hand-offs: payers may have to validate the medical necessity of a procedure before authorizing physicians to provide the service; physicians and members must submit claims to payers; payers need to review and then contact providers to confirm details; payments have to flow through multiple

clearinghouses; and, in some cases, appeals by providers who disagree with the payment amount must be heard.

Further, the US healthcare system is highly regulated. This leads to more administrative spending in areas ranging from adhering to compliance requirements, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to participating in new markets like Medicare Advantage. The intent of policymakers is to provide patients with better healthcare; often, for organizations, new administrative expenses are partially the cost of doing business to meet these requirements. But this can also become another layer of expense into which inefficiencies and errors can creep. Other challenges include the need to manage labor displacement in an industry that is a driver of US workforce growth.³

A new approach

Typical approaches to sizing the opportunity for administrative spending reduction tend to compare the United States to other countries in the Organisation for Economic Co-Operation and Development (OECD). However, the conclusions reached from such an approach may not account for the idiosyncrasies of the US healthcare system and thus may not provide a basis for action. For example, Canada may have lower administrative spending as a percent of total healthcare spending, but it mostly uses a single-payer system that may not provide the level of choice, access, and innovation that the US system fosters and that some Americans demand.

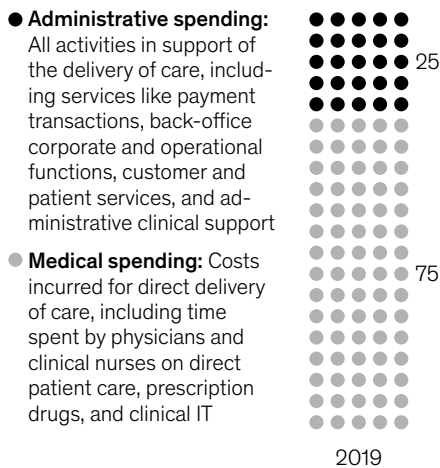
Instead, we offer a pragmatic perspective that addresses how the US healthcare system could reshape administrative spending by payers and providers

Exhibit A

Breakdown of administrative spending by stakeholder group

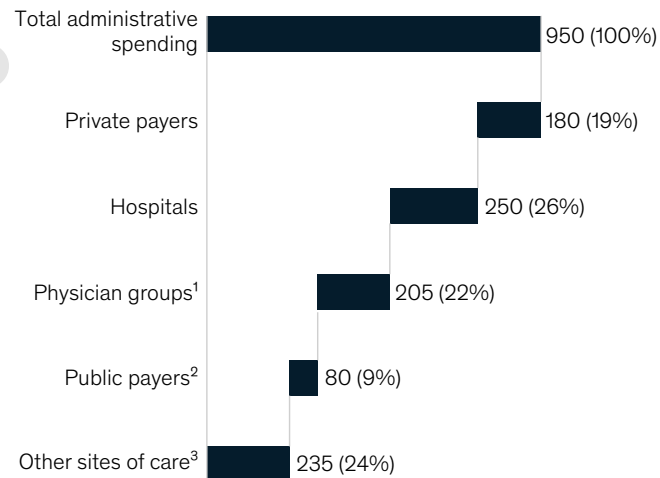
US healthcare spending by type of spending

% of total, 2019 (100% = \$3.8 trillion)



Breakdown by stakeholder group

\$ billion, 2019 (percent of total administrative spending)



Note: Medical spending is not within the scope of this report.

¹ Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

² Includes administrative spending for fee-for-service Medicare and Medicaid, Children's Health Insurance Program (CHIP), Department of Defense, Department of Veterans Affairs, and other federal programs.

³ Includes, for example, dental services, home healthcare, and nursing care facilities.

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

within the current system (Exhibit A).

The goal is not to reduce administrative spending to zero but rather to gain the highest value for each administrative dollar spent without sacrificing quality or access.

Too often, payers' and providers' profit-and-loss (P&L) statements do not provide enough detail to estimate what is necessary and unnecessary spending. Even when they do, the data are not broken down in a way that mimics how the organization operates. From our experience, administrative spending can instead be reorganized into five functional focus areas (Exhibit B):

- **Financial transactions ecosystem:** The movement of all payments, claims, and billing throughout the healthcare ecosystem among payers, hospitals, physician groups, and customers
- **Industry-agnostic corporate functions:** Back-office, non-clinical

functions that are mostly industry-agnostic, such as finance and human resources

- **Industry-specific operational functions:** Back-office, non-clinical functions that are mostly industry-specific, such as underwriting, enrollment, quality reporting, and accreditation
- **Customer and patient services:** The set of activities and processes that provide services to customers, typically done via call centers and increasingly moving toward digital and self-service functions
- **Administrative clinical support functions:** Activities that have a clinical component (for example, nursing administration, case management), which can be customer-facing and require some clinical expertise but are not related to the hands-on care of patients

Saving a quarter-trillion dollars

To our knowledge, this approach to categorizing administrative spending is the first of its kind. It allows us to break up an administrative function into two parts: what work is necessary, and what could be eliminated in the next three years through proven techniques while holding or improving access and quality at today's levels.⁴ By identifying simplification opportunities for each functional focus area, we were able to build a roadmap of about 30 interventions that could deliver up to \$265 billion in annual savings (Exhibit C). This is based on three types of interventions: "within," "between," and "seismic."

The first type is "within" interventions, which can be controlled and implemented by individual organizations. These within interventions could deliver about \$175 billion in annual savings, or 18 percent of total administrative spending. Some examples include automating repetitive work in back-office functions, such as human resources and finance, and integrating a suite of tools and solu-

tions that nurse managers use to manage staffing and budgeting.

Some other interventions can be made "between" organizations. These require agreement and collaboration between organizations but not broader, industry-wide change; they could deliver about \$35 billion in annual savings, or 4 percent of total administrative spending. Building payer-provider communications platforms that unify messaging to customers is one example.

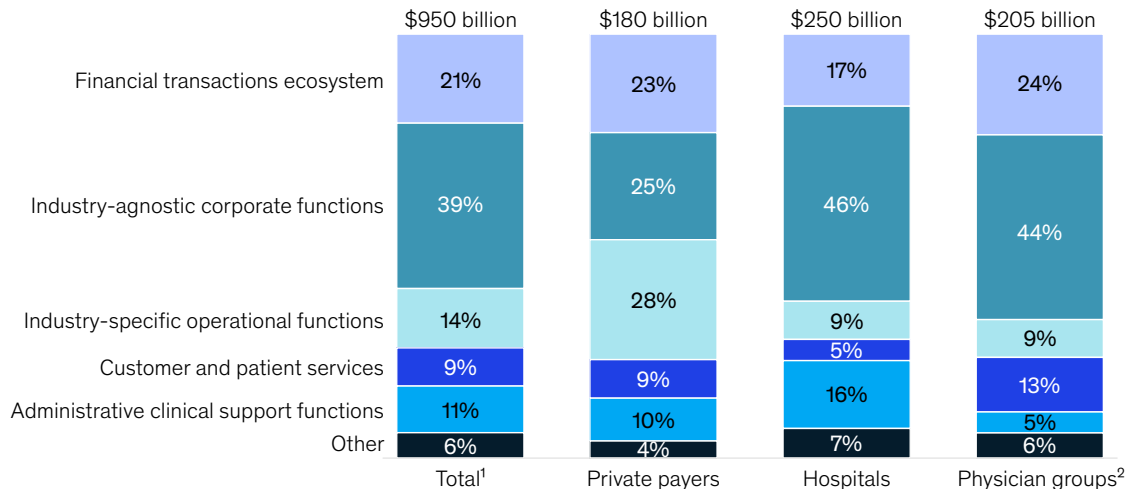
All the within and between interventions have a positive return on investment and, in our experience, can be deployed using current technology and nominal investment (that is, one-time spending of 0.7 to 1.0 times the annual run-rate savings).

The third intervention type is "seismic" and requires broad, structural agreement and changes across the US healthcare system.⁵ These interventions could deliver about \$105 billion in annual savings, or 11 percent of total administrative spending. Seismic interventions—including those that require technology platforms,

Exhibit B

Breakdown of administrative spending by functional focus area

\$ billion, 2019



Note: Figures may not sum to 100%, because of rounding.

¹ Stakeholder groups not shown include public payers (\$80B) and other sites of care (\$235B).

² Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

operational alignment, or payment design—generally benefit from partnerships between the public and private sectors to align incentives for change.

Many seismic interventions address the same sources of spending as the within and between ones but take the savings a step further. Accounting for this overlap, we estimate total savings across all three types of interventions at about \$265 billion, or 28 percent of total administrative spending.⁶

Furthermore, all interventions come with some specific limitations: when deploying these interventions, especially automation,

healthcare organizations must be vigilant to avoid biases, such as algorithms built on skewed data that could adversely affect equity or access for vulnerable populations. In addition, many interventions that rely on automation should be coupled with re-skilling programs that allow existing talent to be placed in higher-value roles.

A roadmap for action

Administrative simplification may not be at the top of stakeholders' priority lists, but the potential to save \$265 billion could be compelling to leaders across healthcare. Even better, these savings are available

Exhibit C

Savings opportunities across known intervention types

Type of known intervention	Example interventions	Savings, \$ billion	Total administrative spending, %
"Within" Interventions that can be controlled and implemented by individual organizations	<ul style="list-style-type: none"> • Financial transactions ecosystem (claims processing): Streamline claims submission process through simplified provider platforms; clarify Explanation of Benefits • Industry-agnostic corporate functions: Automate repetitive work in human resources and finance; build functions of the future leveraging new technologies, such as analytics and cloud computing • Administrative clinical support functions: Remove manual work for nursing managers through automated tools for scheduling and staffing; integrate suite of tools and solutions to communicate 360-degree view of patients to case managers 	~\$175	18
"Between" Interventions that require agreement and collaboration between organizations but not broader, industry-wide change	<ul style="list-style-type: none"> • Financial transactions ecosystem (prior authorization): Align jointly on PA criteria such as medical necessity or required documentation • Customer and patient services: Build strategic payer-provider platforms to reduce demand by proactively sharing data (for example, providing list of in-network specialists to physicians) 	~\$35	4
"Seismic" Interventions that require broad, structural agreement and changes across the US healthcare system	<ul style="list-style-type: none"> • Technology platforms: Adopt a centralized, automated claims clearinghouse; prioritize high-value interoperability use cases • Operational alignment: Standardize medical policies; standardize physician licensure; streamline quality reporting • Payment design: Modularize product design; adopt globally capitated payment models for segments of the care delivery system 	~\$105	11
After accounting for overlap ¹		~\$265	28

¹ We estimated \$50 billion of overlap across within and between interventions and seismic interventions. As a result, the total estimate is not fully additive. Source: Centers for Medicare & Medicaid Services; McKinsey analysis

\$265 billion is greater than Medicare Part A spending (\$201 billion in 2019) and is equivalent to \$1,300 for each American adult.

today. If fully realized, these savings would be more than three times the combined budgets of the National Institutes of Health (\$39 billion), the Health Resources and Services Administration (\$12 billion), the Substance Abuse and Mental Health Services Administration (\$6 billion), and the Centers for Disease Control and Prevention (\$12 billion).⁷ Put another way, \$265 billion is greater than Medicare Part A spending (\$201 billion in 2019) and is equivalent to \$1,300 for each American adult.⁸

Some organizations have made impressive progress on administrative simplification by deploying within and between interventions. At these organizations we found a set of common denominators of success. These include the following:

- Prioritizing administrative simplification as a strategic initiative
- Committing to transformational change versus incremental steps
- Engaging the broader partnership ecosystem on the right capabilities and investments
- Disproportionally allocating resources, such as capital and talent, to the underlying drivers of productivity

Seismic interventions are more difficult, largely because they are generally needed due to a lack of motivation to innovate at the organization level.⁹ For example, today, the Centers for Medicare & Medicaid Services (CMS) requires reporting on more than 1,700 quality measures.¹⁰ Physicians spend the time equivalent to seeing nine patients reporting on such measures weekly.¹¹ Laying out mechanisms that could promote standardization, such as convening a public–private partnership

to identify and streamline to the highest-value measures, could be a seismic way to unlock this opportunity by accelerating technology modernization in organizations (for example, digitizing sources of data).

Apart from the outsize potential for savings, external forces are also creating pressure for organizations to act. Across the US economy, the COVID-19 pandemic and subsequent economic downturn have prompted organizations to rethink operations and invest in digital transformations. Indeed, research has shown that organizations that aggressively pursue industry-leading productivity programs are twice as likely to be in the top quintile of their peers as measured by economic profit.¹²

To galvanize the seismic opportunity, we see actions for three sets of stakeholders:

- *Government* could set the framework in which other organizations operate. Federal and state bodies can set guardrails for payers, hospitals, and physician groups.
- *Investors* can prove ideas with pilots. They might create public–private partnerships to test interventions within a state and then scale up success stories nationally.
- *Third parties*, such as foundations and bipartisan groups, can conduct objective fact gathering and analyses. An arbiter of facts can galvanize action.

There is an opportunity to capture over a quarter-trillion dollars in savings in the next few years without compromising care delivery in the current US healthcare system. There is a clear roadmap ahead with proven solutions; the choice to act is upon everyone.

-
- ¹ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," February 27, 2019, McKinsey.com.
- ² We defined physician groups as hospital-affiliated and independent physician groups with five or more doctors. There are 136,000 active physician groups in the United States ranging in size from solo practices to physician practices with 8,700 members. From "Top physician groups by size and Medicare charges," Definitive Healthcare, Healthcare Insights, 2021, definitivehc.com.
- ³ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," February 27, 2019, McKinsey.com.
- ⁴ We used financial and operational lenses in our analysis but acknowledge the broader benefits these interventions can have on outcomes such as access, quality, patient experience, physician experience, and equity, which we did not focus on or quantify in this report.
- ⁵ We do not propose a comprehensive list of all seismic interventions. We identified a few examples based on analogs from other industries where such interventions delivered a discontinuous but substantial improvement. These example interventions are meant to show the potential in US healthcare but are not a specific point-of-view of what is best or should be pursued.
- ⁶ We estimated \$50 billion of overlap across within and between interventions and seismic interventions.
- ⁷ Office of Budget, "Putting America's health first: FY 2021 President's budget to HHS," Department of Health & Human Services, June 2021, hhs.gov.
- ⁸ Monthly Federal Spending/Revenue/Deficit Charts, US Government Spending, 2021, usgovernmentspending.com.
- ⁹ Nikhil Sahni, Maxwell Wessel, and Clayton Christensen, "Unleashing breakthrough innovation in government," *Stanford Social Innovation Review*, Summer 2013, ssir.org.
- ¹⁰ Gail Wilensky, "The need to simplify measuring quality in health care," *Journal of the American Medical Association*, June 19, 2018, Volume 319, Number 23, pp. 2369–70, jamanetwork.com.
- ¹¹ Lawrence Casalino et al., "US physician practices spend more than \$15.4 billion annually to report quality measures," *Health Affairs*, March 2016, Volume 35, Number 3, healthaffairs.org.
- ¹² Chris Bradley, Martin Hirt, and Sven Smit, *Strategy Beyond the Hockey Stick: People, Probabilities, and Big Moves to Beat the Odds*, Hoboken, NJ: Wiley, 2018.

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Note: By reviewing this paper, no individual is endorsing its conclusions. All errors remain our own.

CHAPTER 1

Introduction

Administrative simplification has been a long sought-after goal in US healthcare, but there has been limited movement in the past few decades. It is clear that some administrative spending is necessary to keep the system running, but it is unclear how much is unnecessary and what could be done to simplify administrative processes. In this report, we lay out a first-of-its-kind analytical framework and break down the \$950 billion in administrative spending in US healthcare into functional focus areas such as the financial transactions ecosystem and customer and patient services. We do so by using average profit-and-loss statements for different stakeholder groups, including private payers, hospitals, and physician groups. For each area, we identify about 30 known interventions that could support simplification. The interventions fall into three types: those that can be achieved “within” each individual organization, those that can be carried out “between” a few organizations, or those that require “seismic” interventions, including public–private partnerships. We estimated that \$265 billion, or 28 percent, of administrative spending could be reduced without affecting quality or access. Our aim is to arm public and private sector leaders with these fact-based insights to guide informed decision making.

In 2019, healthcare spending in the United States reached \$3.8 trillion and comprised 18 percent of US GDP.^{1,2} Over the past 15 years, while US healthcare delivery comprised 9 percent of US GDP growth, the sector represented 29 percent of workforce growth.³ This imbalance suggests major productivity issues in the healthcare system. We defined productivity in previous work in this series as output per given unit of input. In this definition, the outputs in healthcare delivery are largely the services delivered and outcomes achieved; the inputs include the workforce, invested capital, and new technologies. An advantage of looking at healthcare delivery this way is that it puts the focus not on spending minimization, but on long-term growth and overall spending trajectory.⁴

Administrative spending is a subset of total US healthcare spending. We define it as all activities in support of the delivery of care, including services like payment transactions, back-office corporate and operational functions, customer and patient services, and administrative clinical support. Specific functions using traditional terminology include claims processing, billing, accounting, prior authorization, and payment integrity within payments; industry-agnostic corporate functions such as human resources, sales and marketing, finance, and procurement; industry-specific operational functions such as medical records, quality reporting, clinician credentialing, underwriting, transparency tools, and broker management; call centers and medical receptionists within customer and patient services; and nursing administration management tasks (for example, scheduling) and care management teams within administrative clinical support functions. Given the size and necessity of administrative spending in the US healthcare system, we set out to identify opportunities to improve the productivity of administrative functions and to “bend the cost curve” for this bucket of spending.

For clarity, medical spending—or costs incurred for direct delivery of care—were not within the scope of this report. This meant that our analysis excluded areas such as time spent by physicians and clinical nurses on direct patient care, prescription drugs, and clinical IT. Further, we used financial and operational lenses in our analysis, but we acknowledge the broader benefits these interventions can have for outcomes such as access, quality, patient experience, physician experience, and equity, which we did not focus on or quantify in our work.⁵⁻⁷

We estimated that approximately \$950 billion (or 25 percent) of total healthcare spending in 2019 was administrative (Exhibit 1.1).^{8,9} This spending was spread across multiple stakeholder groups: private payers (19 percent), hospitals (26 percent), physician groups (22 percent), public payers (9 percent), and other sites of care (24 percent).¹⁰⁻¹²

For years, researchers and policymakers have asserted that a large portion of this spending could be removed without affecting quality or access. Using various methodologies (for example, comparisons with other countries’ healthcare systems or with other industries), previous analyses estimated that approximately 40 percent of this spending could be eliminated.¹³⁻¹⁸

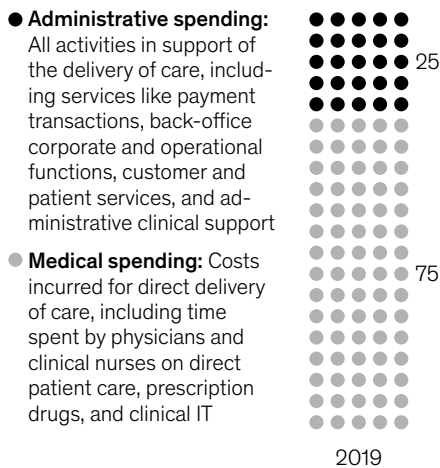
However, these analyses miss important considerations about the US healthcare system. For example, unlike other countries, the United States has a healthcare system that is multi-provider (more than 6,000 hospitals and 11,000 non-employed physician groups with more than five physicians) and multi-payer (more than 900 private payers) to encourage competition.¹⁹⁻²¹ Doing so also increases the complexity of the system due to its greater number of communication and transaction nodes. Underlying this structure is a predominantly fee-for-service payment model, although there has been uptake of value-based models.²² No matter which payment model is used, stakeholder

Exhibit 1.1

Breakdown of administrative spending by stakeholder group

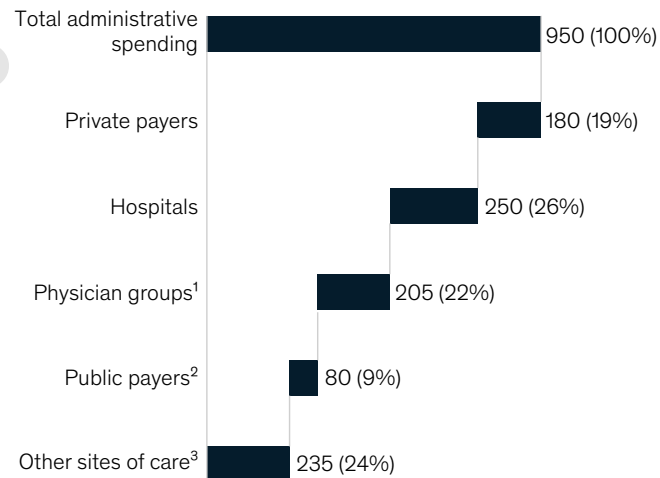
US healthcare spending by type of spending

% of total, 2019 (100% = \$3.8 trillion)



Breakdown by stakeholder group

\$ billion, 2019 (percent of total administrative spending)



Note: Medical spending is not within the scope of this report.

¹ Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

² Includes administrative spending for fee-for-service Medicare and Medicaid, Children's Health Insurance Program (CHIP), Department of Defense, Department of Veterans Affairs, and other federal programs.

³ Includes, for example, dental services, home healthcare, and nursing care facilities.

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

groups continue to put checks and balances on each other to ensure the other party is acting appropriately. The implication is that certain portions of administrative spending are necessary (for example, for service delivery and technology) and others unnecessary (such as excess spending on antiquated systems).

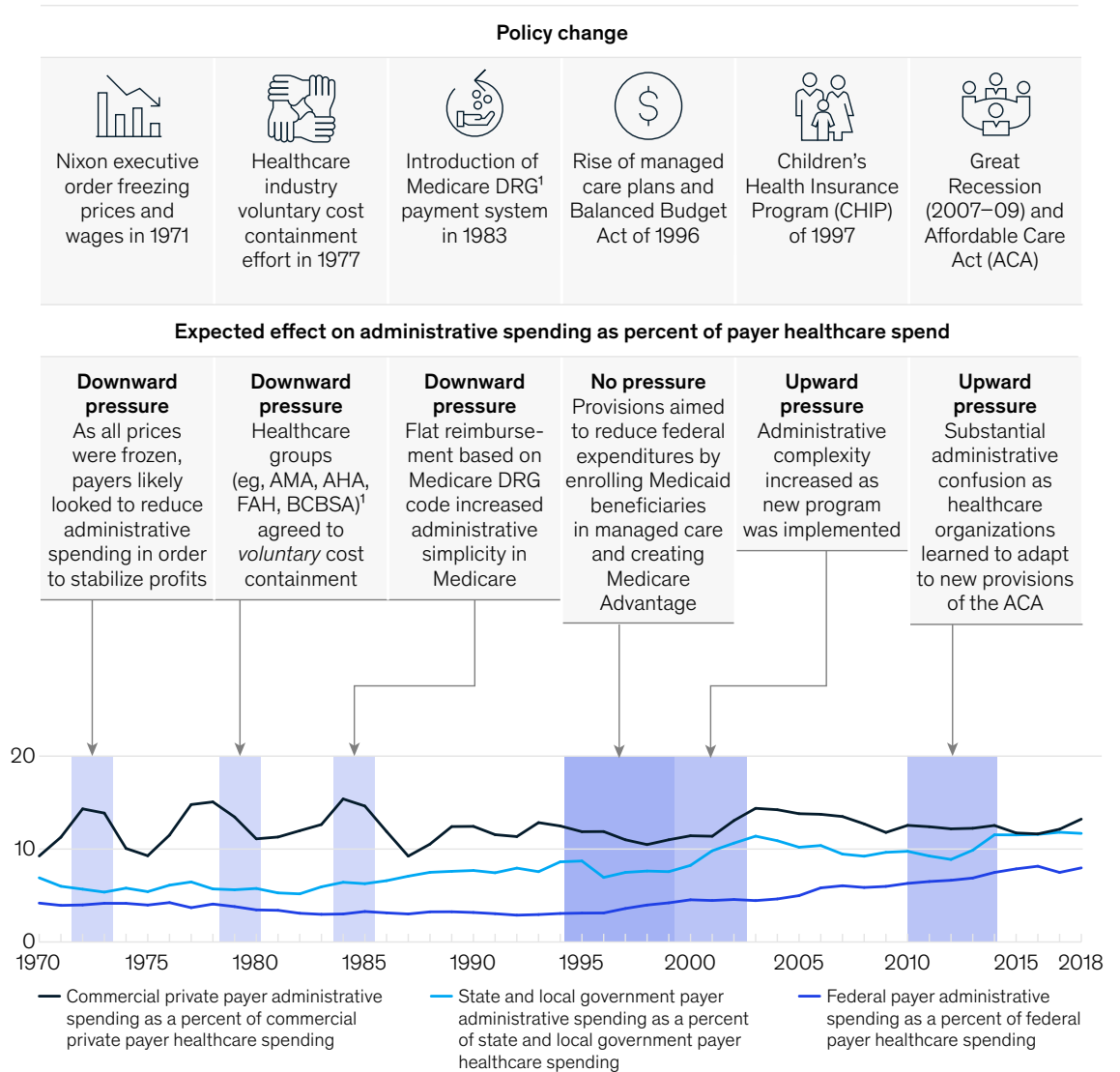
Furthermore, the US healthcare system is highly regulated, requiring administrative spending by organizations to comply with the rules. These regulations range from compliance requirements such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to markets such as Medicare Advantage (MA), a private-sector alternative to traditional Medicare. For example, research has found that physicians spent 2.6 hours per week on quality measure reporting, much of which is not synchronized across payers.²³ That is the equivalent of caring for nine patients. Data released in 2016 by the Information Collection Budget found that

regulations issued by the Department of Health and Human Services are second only to those imposed by the Department of the Treasury in terms of time spent by the private sector.²⁴ Major moments of change in the healthcare system spurred by new policies can substantially affect administrative spending in both positive and negative ways (Exhibit 1.2).²⁵⁻²⁸ For example, the creation of the Affordable Care Act required states to build their own exchanges, including online marketplaces, and payers to invest in reporting on employer size and the extent to which their employees were covered.²⁹ When establishing these regulations, policymakers may generally focus on the impact of a given change on the population, rather than on its effect on the bottom line of payers, hospitals, and physician groups. For example, MA created more competition in the Medicare market, which should be better for members. But the healthcare organization may bear the operational expense of implementing the new policies.

Exhibit 1.2

Major policy changes and evolution in administrative spending over the last 40 years

Administrative spending as a percent of payer healthcare spending



Methodology

Private payers, Commercial: Divided "Net Cost of Health Insurance Expenditures: Private Health Insurance" by "Total National Health Expenditures: Private Health insurance"

Federal payers: Divided "Federal Administration Expenditures" and "Net Cost of Health Insurance Expenditures: Medicare, Federal Medicaid, Federal CHIP" by "Total National Health Expenditures: Federal Expenditures, Medicare, Federal Medicaid, Federal CHIP, DoD, and DVA"

State and local payers: Divided "State and Local Administration Expenditures" and "Net Cost of Health Insurance Expenditures: State and Local Medicaid, State and Local CHIP" by "Total National Health Expenditures: State Expenditures, State and Local Medicaid, State and Local CHIP, Other State and Local Programs"

Note: Similar figures not available for providers.

¹ AHA, American Hospital Association; AMA, American Medical Association; BCBSA, Blue Cross Blue Shield Association; DRG, diagnosis-related group; FAH, Federation of American Hospitals.

Source: Centers for Medicare & Medicaid Services; Marsha Gold et al., "Effects of selected cost-containment efforts: 1971–1993," *Health Care Financ Rev*, 1993, 14(3): 183–225; Stuart Guterman and Allen Dobson, "Impact of the Medicare prospective payment system for hospitals," *Health Care Financ Rev*, 1986, 7(3): 97–114; Andy Schneider, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105–33," CBPP, 1997; McKinsey analysis

In the case of MA, the change led many payers to hire a larger administrative workforce to code and audit patient risk scores.³⁰

Given this background, what portion of administrative spending is actually necessary? What amount could be reduced through simplification, and how might that happen without compromising access and quality? To help move the national discussion forward, we set forth to build a granular, bottom-up breakdown of administrative spending (see more detail in chapter 2) for three key private stakeholder groups—private payers, hospitals, and physician groups. To the best of our knowledge, this is the first-of-its-kind analysis of US healthcare administrative spending. These three stakeholder groups accounted for approximately \$635 billion of the \$950 billion of US healthcare administrative spending in 2019. By compiling these figures from average profit-and-loss statements, we were able to systematically categorize interventions and estimate capturable savings in five functional focus areas: the financial transactions ecosystem, industry-agnostic corporate functions, industry-specific operational functions, customer and patient services, and administrative clinical support functions. These comprised 94 percent of total US administrative spending.

Chapters 3 through 7 of this report explore each of the five functional focus areas in detail. We then identify known interventions that could simplify administrative processes and reduce spending without sacrificing quality or access. To do so, we used three criteria: proven but not fully scaled changes across US healthcare, changes related to technology that will fully come to market within the next three years, and transformational changes that are analogous to those implemented in other US industries. We grouped these criteria into one of three categories based on where stakeholders must reach “agreement” to effectuate change:

- **“Within”**: Interventions that can be controlled and implemented by individual organizations
- **“Between”**: Interventions that require agreement and collaboration between organizations, but not broader, industry-wide change
- **“Seismic”**: Interventions that require broad, structural agreement and changes across the US healthcare system

We used this construct because it allows for the development of an actionable roadmap and more accurately identifies the burden of responsibility for each stakeholder group in the healthcare system. For each functional focus area, we discuss the within and between interventions in its respective chapter. Seismic interventions are discussed separately (see chapter 8). Our list of seismic interventions is not comprehensive. We identified a few examples based on analogs from other industries where such interventions delivered a discontinuous but substantial improvement. These example interventions are meant to show the potential in US healthcare but are not a specific point-of-view on what is best or should be pursued.

We found that approximately \$175 billion (or 18 percent of the \$950 billion total administrative spending) could be saved through within interventions (for example, automating rules-based tasks in back-office functions) and another \$35 billion (or 4 percent) through between interventions (for example, setting up a joint claims-status-tracking workflow between payers and providers). This overall total of \$210 billion (or 22 percent) represented net savings after accounting for ongoing operating expenses; based on our experience, they require a one-time investment of 0.7 to 1.0 times the annual run-rate savings. About \$105 billion (or 11 percent) could be saved through seismic interventions that require foundational shifts in how the US healthcare system operates (for example, adopting a centralized, automated claims clear-

inghouse or standardizing medical policies). Many of these seismic interventions could replace certain within and between interventions, resulting in total identified savings of \$265 billion (or 28 percent).

This amount is less than the 40 percent, top-down estimate of unnecessary administrative spending cited from previous literature above. By contrast, our estimate reflects a unique methodology offering a bottom-up roadmap of what savings could be practically and realistically captured in the next three years without affecting quality or access. Furthermore, the focus on practicality helped to prioritize interventions with a high

return on investment for a given organization, such as payment integrity for payers or revenue cycle management for providers.

In the rest of this report, we will review each functional focus area and break down the spending by each of the three stakeholder groups (private payers, hospitals, and physician groups), explain the major pain points that result in unnecessary administrative spending, and describe interventions that could be used to capture savings. Finally, we will discuss how leaders across sectors might catalyze this change (see chapter 9) and share specific actions for each stakeholder group to consider.

- ¹ National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov.
- ² United States GDP (current US dollars), The World Bank Group, 2021, data.worldbank.org.
- ³ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," February 27, 2019, McKinsey.com.
- ⁴ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," February 27, 2019, McKinsey.com.
- ⁵ Michael Kyle and Austin Frakt, "Patient administrative burden in the US health care system," *Health Services Research*, September 8, 2021, pp. 1–11, onlinelibrary.wiley.com.
- ⁶ David Cutler and Dan Ly, "The (paper) work of medicine: understanding international medical costs," *Journal of Economic Perspectives*, Spring 2011, Volume 25, Number 2, pp. 3–25, aeaweb.org.
- ⁷ Lawrence Casalino et al., "US physician practices spend more than \$15.4 billion annually to report quality measures," *Health Affairs*, March 2016, Volume 35, Number 3, pp. 401–6, healthaffairs.org.
- ⁸ National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov.
- ⁹ James Kahn et al., "The cost of health insurance administration in California: Estimates for insurers, physicians, and hospitals," *Health Affairs*, November 2005, Volume 24, Number 6, pp. 1629–39, healthaffairs.org.
- ¹⁰ Includes categories such as dental services, home health, nursing care facilities, other professional services, and other health, personal, and residential care.
- ¹¹ "National health expenditure accounts: Methodology paper, 2019," Centers for Medicare & Medicaid Services, 2019, cms.gov.
- ¹² National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov.
- ¹³ Natasha Parekh, Teresa Rogstad, and William Shrank, "Waste in the US health care system: Estimated costs and potential for savings," *Journal of the American Medical Association*, October 2019, Volume 322, Number 15, pp. 1501–9, jamanetwork.com.
- ¹⁴ Tanya Bentley et al., "Waste in the U.S. health care system: A conceptual framework," *The Milbank Quarterly*, December 2008, Volume 86, Number 4, pp. 629–59, doi:10.1111/j.1468-0009.2008.00537.x.
- ¹⁵ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," February 27, 2019, McKinsey.com.
- ¹⁶ Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*, Washington, DC: The National Academies Press, 2010.
- ¹⁷ Donald Berwick and Andrew Hackbarth, "Eliminating waste in US health care," *Journal of the American Medical Association*, April 2012, Volume 307, Number 14, pp. 1513–6, jamanetwork.com.
- ¹⁸ Terry Campbell, David Himmelstein, and Steffie Woolhandler, "Health care administrative costs in the United States and Canada, 2017," *Annals of Internal Medicine*, January 2020, Volume 172, Number 2, pp. 134–42, acpjournals.org.
- ¹⁹ American Hospital Association, "Fast facts on U.S. hospitals, 2021," partial data from 2019 survey, updated January 2021, aha.org.
- ²⁰ We defined physician groups as hospital-affiliated and independent physician groups with five or more doctors. There are 136,000 active physician groups in the United States ranging in size from solo practices to physician practices with 8,700 members. From "Top physician groups by size and Medicare charges," *Definitive Healthcare*, Healthcare Insights, 2021, definitivehc.com.
- ²¹ Facts + statistics: Industry overview, Insurance Information Institute, August 2021, iii.org.
- ²² A fee-for-service model is one in which hospitals and physician groups are paid based on the amount of healthcare services they deliver. A value-based care model is one where they are paid based on patient outcomes.
- ²³ Lawrence Casalino et al., "US physician practices spend more than \$15.4 billion annually to report quality measures," *Health Affairs*, March 2016, Volume 35, Number 3, pp. 401–6, healthaffairs.org.
- ²⁴ Nikhil Sahni, Pooja Kumar, Edward Levine, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," February 27, 2019, McKinsey.com.
- ²⁵ National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov.
- ²⁶ Marsha Gold et al., "Effects of selected cost-containment efforts: 1971–1993," *Health Care Financing Review*, 1993, Volume 14, Number 3, pp. 183–225.
- ²⁷ Stuart Guterman and Allen Dobson, "Impact of the Medicare prospective payment system for hospitals," *Health Care Financing Review*, 1986, Volume 7, Number 3, pp. 97–114.
- ²⁸ Andy Schneider, "Overview of Medicaid provisions in the Balanced Budget Act of 1997, P.L. 105–33," Center on Budget and Policy Priorities, September 1997, cbpp.org.
- ²⁹ "Read the Affordable Care Act," Centers for Medicare & Medicaid Services, 2021, healthcare.gov.
- ³⁰ Office of the Actuary, "Risk score credibility guidelines," Centers for Medicare & Medicaid Services, April 2015, cms.gov.

CHAPTER 2

Analytical framework

Historical analyses of the savings potential from administrative simplification typically use top-down comparisons of the United States and other countries such as Canada. Our goal was to connect the *macro*, an estimated \$950 billion in administrative spending in 2019, to the *micro*, the average profit-and-loss (P&L) for private payers, hospitals, and physician groups. We did this by creating five functional focus areas of spending that cut across all stakeholder groups: the financial transactions ecosystem (\$200 billion), industry-agnostic corporate functions (\$375 billion), industry-specific operational functions (\$135 billion), customer and patient services (\$80 billion), and administrative clinical support functions (\$105 billion).^{*} By doing this, we can isolate what spending is necessary versus what could be removed through known interventions and scaled in the next three years while maintaining or improving access and quality.

^{*}The remaining \$55 billion was categorized as "other" and includes spending such as public relations and charitable giving.

Our goal was to answer the core questions of what portion of administrative spending is actually necessary and what amount could be reduced without compromising access and quality. To do so, we needed to develop estimates of overall administrative spending and then break that spending down into functional focus areas.

Estimation of overall administrative spending

Over the past two decades, research has consistently found that about 25 percent, ranging from 15 to 35 percent, of US healthcare spending was for administrative functions.¹⁻³ We sought to refresh this research and confirm the validity of earlier estimates. We assumed that the overall percentage of 25 percent has remained constant for two reasons. First, we ran a series of regressions of “excess spending adjusted for wealth” from 2010

to 2019 and found that the categories of healthcare spending in the United States have not shifted substantially.⁴⁻⁶ Second, increased administrative spending reflecting innovation and responses to regulations likely counteracted potential savings from any new interventions.

We further confirmed the overall estimate by focusing on three individual stakeholder groups—private payers, hospitals, and physician groups. Using these results, we estimated administrative spending for the two remaining stakeholder groups of public payers and other sites of care (Exhibit 2.1).

For hospitals and physician groups, we reviewed blinded data for more than 50 individual organizations and found administrative spending equaled 20 to 25 percent of revenue for hospitals and 25 to 30 percent for physician groups. Using 2019 National Health Expenditure Accounts (NHEA) data, we found that

Exhibit 2.1

Key stakeholder groups in analytical focus for this report

■ Analytical focus (67% of total administrative spending) ■ Extrapolated full savings potential (100% of total administrative spending)

		Functional focus areas					
Stakeholder groups		Financial transactions ecosystem	Industry-agnostic corporate functions	Industry-specific operational functions	Customer and patient services	Administrative clinical support functions	Other ⁴
Payers	Public ¹	↑	↑	↑	↑	↑	↗
	Private	■	■	■	■	■	■
Providers	Hospitals	■	■	■	■	■	→
	Physician groups ²	■	■	■	■	■	■
Other sites of care ³		↓	↓	↓	↓	↓	↘

¹Includes administrative spending for fee-for-service Medicare and Medicaid, Children's Health Insurance Program (CHIP), Department of Defense, Department of Veterans Affairs, and other federal programs.

²Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

³Includes, for example, dental services, home healthcare, and nursing care facilities.

⁴Includes miscellaneous activities such as charitable giving, community health education, and public relations.

Source: McKinsey analysis

Exhibit 2.2

Deriving administrative spending from who is paying and where it is being spent

Stakeholder group	Total healthcare spending, \$ billion			Administrative spending as a percent of total spending
	Who is paying? ¹	Where it is being spent ²	Administrative spending	
Public payers	1,558 ³	—	80	5%
Private payers	1,195	—	180	15%
Hospitals	—	1,192	250	21%
Physician groups ⁴	—	772	205	27%
Other sites of care ⁵	—	734	235	32%
Not included in analysis	1,042 ⁶	1,097 ⁷	N/A	N/A
Total	3,795	3,795	950	25%

¹ Based on 2019 National Health Expenditure Accounts (NHEA) "Source of Funds" table.

² Based on NHEA "Type of Expenditure" table.

³ Sum of 2019 NHEA Medicare (\$799B), Medicaid (\$614B) and other health insurance programs (for example, CHIP) spending (\$145B).

⁴ Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

⁵ Sum of 2019 NHEA dental services (\$143B); home healthcare (\$114B); nursing facilities (\$174B); other health, residential, and personal care (\$194B); and other professional services (\$111B).

⁶ Includes government public health activities (\$98B), investment (\$202B), out-of-pocket spending (\$407B), and third-party payers (for example, workforce comp; \$336B).

⁷ Includes government administration (\$49B), government public health activities (\$98B), investment (\$202B), net cost of health insurance (\$240B), and retail outlet sales of medical products (\$509B).

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

our estimate indicated total administrative spending of \$250 billion and \$205 billion, respectively.⁷

For private payers, we reviewed blinded data for more than 30 individual organizations and found administrative spending was equal to roughly 15 percent of revenue. Using 2019 NHEA data, this figure resulted in total administrative spending of \$180 billion. We compared this total to the sum of the net cost of health insurance expenditures on private health insurance (\$131 billion in 2019) and approximately 60 percent of the expenditures on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), a percentage which represents the managed-care portion of Medicare and Medicaid enrollment (\$48 billion in 2019).⁸ We found that the NHEA and net cost totals were about the same.

For public payers, NHEA reports the following data. We summed state and

federal administration spending (\$49 billion in 2019) and approximately 40 percent of the net cost of health insurance expenditures on Medicare, Medicaid, and CHIP, which represents the fee-for-service portion of Medicare and Medicaid enrollment (\$32 billion in 2019).⁹ This calculation produced an estimate of approximately \$80 billion in total administrative spending.

In addition to these four stakeholder groups, we created an "other sites of care" group representing the remainder of administrative spending. Examples in this group included dental services, home healthcare, and nursing care facilities. In total, administrative spending for this group was estimated to be \$235 billion. This value was about 30 percent of total revenue in these other sites of care, an estimate that corresponded with our review of blinded data from more than 40 individual organizations across these categories.

Three stakeholder groups—private payers, hospitals, and physician groups—represented 70 percent of all administrative spending.

Our analyses showed the administrative spending baseline across the five stakeholder groups to be \$950 billion (Exhibit 2.2).

Functional breakdown of administrative spending

As a next step, we developed a set of five functional focus areas that cut across the stakeholder groups; these helped us align known interventions that could deliver savings (see chapters 3–7). Given data limitations, we focused our analysis on three stakeholder groups—private payers (including pharmacy benefit managers, or PBMs), hospitals, and physician groups—which represented 70 percent of all administrative spending.¹⁰

For these stakeholder groups, we used profit-and-loss (P&L) statements based on blinded data from private payers, hospitals, and physician groups. These P&Ls use standard accounting definitions. To make the standard accounting groupings actionable, we converted them into functional focus areas based on actual operational activities (see below for details by stakeholder group):

- **Financial transactions ecosystem:** The movement of all payments, claims, and billing throughout the healthcare ecosystem among payers, hospitals, physician groups, and customers
- **Industry-agnostic corporate functions:** Back-office, non-clinical functions that are mostly industry-agnostic, such as finance or human resources
- **Industry-specific operational functions:** Back-office, non-clinical functions that are mostly industry-specific,

such as underwriting, enrollment, quality reporting, and accreditation

- **Customer and patient services:** The set of activities and processes that provide services to customers, typically done via call centers and increasingly moving toward digital and self-service functions
- **Administrative clinical support functions:** Activities that have a clinical component (for example, nursing administration, case management), which can be customer-facing and require some clinical expertise, but are not related to the hands-on care of patients

Breaking down a P&L statement into these functional focus areas may look familiar to payers that already examine their finances in terms of administrative versus medical spending and also already use some of this terminology. However, these functional focus areas will likely be unfamiliar to hospitals and physician groups as they may not differentiate explicitly between administrative versus medical spending. They also typically assess their P&L statements in terms of “Net Patient Service revenue,” or per-patient metrics of revenue (instead of total spending). For our purposes, we needed to use common terminology and definitions across all stakeholder groups so we could identify cross-stakeholder interventions.

Private payers

Three functional focus areas accounted for about 76 percent of the \$180 billion that private payers spent on administrative functions in 2019: industry-specific operational functions (\$50 billion), industry-

agnostic corporate functions (\$45 billion), and the financial transactions ecosystem (\$40 billion) (Exhibit 2.3).

Industry-specific operational functions for private payers include specialized broker-based sales; underwriting, actuarial and pricing; clinician credentialing; and membership and billing. Industry-agnostic corporate functions include many standard operations for organiza-

tions, such as general administration, sales and marketing support, and IT. The financial transactions ecosystem, which forms the backbone of payments for private payers, includes claims and utilization management. Beyond these three functional focus areas, customer and patient services (\$20 billion) and administrative clinical support functions (\$20 billion) each accounted for approximately 10 percent of total private payer administra-

Exhibit 2.3

Private payers: Representative operating activity profit-and-loss statements

Total administrative spending, \$ billion, 2019	Functional focus area, \$ billion						Total administrative spending
	Financial transactions ecosystem	Industry-agnostic corporate functions	Industry-specific operational functions	Customer and patient services	Administrative clinical support functions	Other	
General administration	0.0	16.3	0.0	0.0	0.0	0.0	16.3
Claims	29.0	0.0	0.0	0.0	0.0	0.0	29.0
Sales and marketing	0.0	10.9	16.3	0.0	0.0	0.0	27.1
Underwriting/actuarial/pricing	0.0	0.0	21.7	0.0	0.0	0.0	21.7
Membership and billing	0.0	0.0	3.6	0.0	0.0	0.0	3.6
Clinician services and credentialing	0.0	0.0	14.5	0.0	0.0	0.0	14.5
Customer service	0.0	0.0	0.0	12.7	0.0	0.0	12.7
IT ¹	4.3	13.0	0.0	4.3	0.0	0.0	21.7
Utilization management/quality review	7.2	0.0	0.0	0.0	0.0	0.0	7.2
Case management	0.0	0.0	0.0	0.0	5.4	0.0	5.4
Medical director	0.0	0.0	0.0	0.0	5.4	0.0	5.4
Other healthcare services ²	0.0	0.0	0.0	0.0	7.2	7.2	14.5
Total (percent of total)	40 (23%)	45 (25%)	50 (28%)	20 (9%)	20 (10%)	5 (4%)	180 (100%)

Note: Figures may not sum to 100%, because of rounding.

¹IT spending for utilization management/quality review and case management are represented in those specific line items, and not in the IT line item.

²Contains mix of clinical support operations (for example, behavioral health, wellness) and other vendor spending (for example, subrogation).

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

tive spending. The former comprises call centers and the associated IT to support them; the latter includes resources within case management and those allocated to medical directors that enable private payers to manage care for patients with complex needs.

Hospitals

Of the \$250 billion that hospitals (defined for our purposes as hospital systems and employed physician groups) spent on administrative functions in 2019, the largest functional focus area (approximately \$115 billion, or 46 percent of total administrative spending) was industry-agnostic corporate functions (Exhibit 2.4). This spending is driven by the large back-office operations that hospitals rely on to facilitate care provision, as well as by the administrative work that hospitals provide for employed physician groups.¹¹ Specific functions include general administration, accounting, and non-clinical IT.

Hospitals' sales and marketing function also resides within industry-agnostic corporate functions. In our experience, while spending in this area is growing, the actual level is too low to be a major factor in overall administrative spending. For example, the most sophisticated hospitals adopting digital tools to attract patients are spending no more than 1 to 2 percent of their total administrative budgets on sales and marketing.

The next two largest functional focus areas were the financial transactions ecosystem (\$40 billion) and administrative clinical support functions (\$40 billion). The former includes the "cost to collect" or revenue cycle management function that allows hospitals to identify,

manage, and collect patient service revenue. The latter includes administrative spending on two types of nurses: nursing administration, or the managerial layer of nurses who are fully administratively focused and handle non-patient-facing tasks such as staffing and budgeting, and case and disease management, which includes nurses who spend 30 to 40 percent of their time on administrative tasks such as communication and coordination of patient status across both registration and discharge.

Hospitals spent roughly \$20 billion, or 9 percent of total administrative spending, on industry-specific operational functions such as medical records management and quality reporting. Finally, hospitals spent about \$10 billion, or 5 percent of total administrative spending, on customer and patient services such as call centers. A long tail of smaller expenses were represented by the "other" category, including spending on charity, religious, and spiritual activities (for example, chaplains), and public relations.

Physician groups

Similar to hospitals, about 44 percent of the \$205 billion that non-employed physician groups spent on administrative activities in 2019 was for industry-agnostic corporate functions (\$90 billion). These functions include general administration, administrative supplies and services, and non-clinical IT (Exhibit 2.5). The next-largest functional focus area was the financial transactions ecosystem (\$50 billion, or about 24 percent of total administrative spending), which includes claims and billing, utilization management, and non-clinical IT, such as provider portals. The third

Industry-agnostic corporate functions represented about 45 percent of administrative spending for both hospitals and physician groups.

largest functional focus area was customer and patient services (\$25 billion, or 13 percent), which includes spending on medical receptionists that answer

patients' questions, typically about payments and appointment scheduling. The two remaining, smaller functional focus areas were industry-

Exhibit 2.4

Hospitals: Representative operating activity profit-and-loss statements

Total administrative spending, \$ billion, 2019	Functional focus area, \$ billion						Total administrative spending
	Financial transactions ecosystem	Industry-agnostic corporate functions	Industry-specific operational functions	Customer and patient services	Administrative clinical support functions	Other	
Hospital administration ¹	0.0	75.1	0.0	0.0	0.0	0.0	75.1
Other administration	0.0	14.3	0.0	0.0	0.0	0.0	14.3
General accounting	0.0	13.1	0.0	0.0	0.0	0.0	13.1
Other fiscal	0.0	1.2	0.0	0.0	0.0	0.0	1.2
Patient accounting	19.1	0.0	0.0	0.0	0.0	0.0	19.1
Claims submission, credit, and collection	11.9	0.0	0.0	0.0	0.0	0.0	11.9
Public relations	0.0	0.0	0.0	0.0	0.0	9.5	9.5
Medical receptionists	0.0	0.0	0.0	11.9	0.0	0.0	11.9
Personnel	0.0	9.5	0.0	0.0	0.0	0.0	9.5
Nursing administration	0.0	0.0	0.0	0.0	15.5	0.0	15.5
Admitting and registration ²	0.0	0.0	0.0	0.0	21.5	0.0	21.5
In-service education	0.0	0.0	0.0	0.0	3.6	0.0	3.6
Utilization management	10.7	0.0	0.0	0.0	0.0	0.0	10.7
Medical records	0.0	0.0	22.6	0.0	0.0	0.0	22.6
Other healthcare services ³	0.0	0.0	0.0	0.0	0.0	8.3	8.3
Total (percent of total)	40 (17%)	115 (46%)	20 (9%)	10 (5%)	40 (16%)	20 (7%)	250 (100%)

Note: Figures may not sum to 100%, because of rounding.

¹ Includes sales spending (no more than 1–2% of total hospital administrative spending).

² Includes admitting, medical staff's administrative activities, and outpatient registration.

³ Comprised of miscellaneous charity and wellness spending (for example, chaplain services, governing board, employee health).

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

specific corporate functions (\$20 billion, or 9 percent) and administrative clinical support functions (\$10 billion, or 5 percent). The former includes functions such as medical records management and quality reporting; the latter includes resources to support the administrative infrastructure of coordination and communication of patient care through case management and medical secretaries and transcribers.

Summary of analytical framework

For the US healthcare system, these five functional focus areas represented about 94 percent of total administrative spending, though this varies by stakeholder group (Exhibit 2.6).

For private payers, these five functional focus areas comprised 96 percent of the \$180 billion in total administrative spending. The largest (28 percent) was

Exhibit 2.5

Physician groups: Representative operating activity profit-and-loss statements

Total administrative spending, \$ billion, 2019	Functional focus area, \$ billion						Total administrative spending ¹
	Financial transactions ecosystem	Industry-agnostic corporate functions	Industry-specific operational functions	Customer and patient services	Administrative clinical support functions	Other	
General administration	0.0	25.5	0.0	0.0	0.0	0.0	25.5
Other administrative support	0.0	3.1	0.0	0.0	0.0	0.0	3.1
Contracted services	0.0	11.6	0.0	0.0	0.0	0.0	11.6
Administrative supplies and services	0.0	21.6	0.0	0.0	0.0	0.0	21.6
Claims/billing office	30.1	0.0	0.0	0.0	0.0	0.0	30.1
Medical receptionists	0.0	0.0	0.0	26.3	0.0	0.0	26.3
Managed care administration	4.6	0.0	0.0	0.0	4.6	0.0	9.3
IT	6.3	19.0	6.3	0.0	0.0	0.0	31.7
Utilization management	8.9	0.0	0.0	0.0	0.0	0.0	8.9
Medical secretaries/transcribers	0.0	0.0	0.0	0.0	5.4	0.0	5.4
Medical records	0.0	0.0	11.6	0.0	0.0	0.0	11.6
Other healthcare services	0.0	9.4	0.0	0.0	0.0	10.2	28.6
Total¹ (percent of total)	50 (24%)	90 (44%)	20 (9%)	25 (13%)	10 (5%)	10 (6%)	205 (100%)

Note: Figures may not sum to 100%, because of rounding.

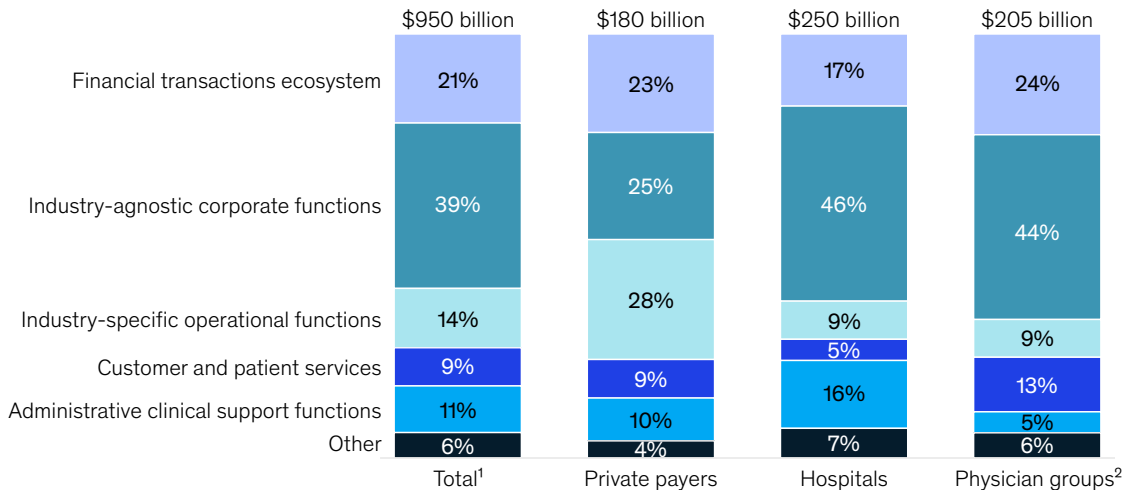
¹ Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

Exhibit 2.6

Breakdown of administrative spending by functional focus area

\$ billion, 2019



Note: Figures may not sum to 100%, because of rounding.

¹ Stakeholder groups not shown include public payers (\$80B) and other sites of care (\$235B).² Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

industry-specific operational functions, followed by industry-agnostic corporate functions (25 percent), the financial transactions ecosystem (23 percent), administrative clinical support functions (10 percent), and customer and patient services (9 percent). Unlike hospitals and physician groups, private payers spent almost 50 percent less on industry-agnostic corporate functions as a percentage of total administrative spending, owing to higher rates of automation and digitalization. Private payers also had a significantly larger portion of administrative spending allocated to industry-specific operational functions such as underwriting or broker-specific sales, as these are strategic capabilities that allow them to differentiate themselves in the market (for example, through highly tailored pricing or data-driven negotiations with brokers).

For hospitals, these functional focus areas comprised about 93 percent of the \$250 billion in total administrative spending. The largest (46 percent) was

in industry-agnostic corporate functions, followed by the financial transactions ecosystem (17 percent), administrative clinical support functions (16 percent), industry-specific operational functions (9 percent), and customer and patient services (5 percent). This high proportion of hospital spending on industry-agnostic corporate functions was also seen in physician groups. A fragmented provider market and the resulting lack of scale could account for this finding.¹²

For physician groups, these functional focus areas comprised about 94 percent of the \$205 billion in total administrative spending. The largest (44 percent) was in industry-agnostic corporate functions, followed by the financial transactions ecosystem (24 percent), customer and patient services (13 percent), industry-specific operational functions (9 percent), and administrative clinical support functions (5 percent). Physician groups spent more than hospitals on the

financial transactions ecosystem and customer and patient services as a percentage of total administrative spending. This could reflect the inability of many physician groups to afford

investments in automation technology to reduce manual work, which can include eligibility checks and pre-authorizations or providing self-service scheduling tools for patients.

- ¹ James Kahn et al., "The cost of health insurance administration in California: Estimates for insurers, physicians, and hospitals," *Health Affairs*, 2005, Volume 24, Number 6, pp, 1629–39, healthaffairs.org.
- ² Erin Michael, "A third of US health care spending stems from administrative costs," *Healio*, January 6, 2020, healio.com.
- ³ Joshua Gottlieb and Mark Shepard, "How large a burden are administrative costs in health care," *Econofact*, September 6, 2018, econofact.org.
- ⁴ Carlos Angrisano, Diana Farrell, Bob Kocher, Martha Laboissiere, and Sara Parker, "Accounting for the cost of health care in the United States," January 1, 2007, McKinsey.com.
- ⁵ Diana Farrell, Eric Jensen, Bob Kocher, Nick Lovegrove, Fareed Melhem, Lenny Mendonca, and Beth Parish, "Accounting for the cost of US health care: A new look at why Americans spend more," December 1, 2008, McKinsey.com.
- ⁶ Jesse Bradford, David Knott, Edward Levine, and Rodney Zimmel, "Accounting for the cost of US healthcare: Pre-reform trends and the impact of the recession," December 2011, McKinsey.com.
- ⁷ National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov.
- ⁸ We assume the net cost of health insurance is fully administrative spending, which is defined by the NHEA as "the difference between calendar-year (CY)-incurred premiums earned and benefits paid for private health insurance. This includes administrative spending, and, in some cases, additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses." Sourced from National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov. The managed care portion of the net cost of health insurance was calculated as 60 percent based on the fact that managed care lives across Medicaid and Medicare made up 60 percent of the total Medicaid and Medicaid lives in 2019, based on data from the Kaiser Family Foundation.
- ⁹ National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov; CMS NHEA, 2019. The managed care portion of the net cost of health insurance was calculated as 60 percent based on the fact that managed care lives across Medicaid and Medicare made up 60 percent of total Medicaid and Medicaid lives in 2019, based on data from the Kaiser Family Foundation.
- ¹⁰ We did not do deep dives into the other two stakeholder groups (public payers and other sites of care) in an effort to focus on the stakeholder groups with the highest administrative spending. However, we do apply adjusted and conservative savings estimates to aggregate the overall opportunity for the US healthcare system. This is important because all stakeholder groups, including Medicare, have a substantial opportunity to simplify administrative functions and could also benefit from the seismic interventions discussed in chapter 8.
- ¹¹ There may also be IT spending specific to certain functions in other functional focus areas.
- ¹² As of 2018, the top five health systems together account for only about 13 percent of annual hospital admissions. Sourced from Neha Patel, Lisa Foo, and Saum Sutaria, "The Silent Shapers of Health Care," September 2018, McKinsey.com.

CHAPTER 3

Financial transactions ecosystem

The financial transactions ecosystem comprises the movement of all payments, claims, and billing throughout the healthcare ecosystem among payers, hospitals, physician groups, and customers. Representing \$200 billion in annual administrative spending (or 21 percent of total administrative spending), it includes functions such as claims processing and prior authorization (PA) for payers and major portions of revenue cycle management for providers. Salient challenges include high levels of product customization that give rise to payment complexity, highly manual processes, lack of coordination between stakeholder groups on data definitions and payment processes, and non-standardized system-level workflows such as claims payments and underlying medical documentation. “Within” interventions (such as the simplification of products and their associated rules and the automation of rules-based tasks), along with “between” interventions (such as building a unified claims tracking system and aligning jointly on PA criteria), could deliver \$40 billion in annual savings.

The financial transactions ecosystem involves the processes through which payers and providers manage payments; it starts with the determination of medically necessary services and includes providers' submission of claims for those services, as well as payment for those services by payers based on pre-negotiated rates between the various parties.

This ecosystem is complex for a number of reasons. First, the United States is a multi-hospital, multi-physician group, and multi-payer system—meaning that to complete the claims and payments process, payers and providers must communicate with a multitude of organizations, many of which have different definitions of medical necessity and services rendered, business rules, and data requirements. Second, the US healthcare system largely operates in a fee-for-service paradigm. Payers and providers are on the opposite sides of a push-and-pull system that engenders a meaningful number of checks and validations across the claims journey, including PA, submission, adjudication, and appeals.

Additionally, each touchpoint during a patient visit (for example, inpatient admission, laboratory tests) can result in a separate claim in the billing system; even when a claim is billed at the episode level, each service must be billed as a separate line item. Furthermore, the same service, such as a laboratory test, may be processed differently based on the site of care. Finally, each claim comprises multiple parts depending on a patient's insurance (for example, copay, deductible). This complexity not only must be managed by payers through their claims processing systems but also by hospitals and physician groups as they track revenue for each patient service from initial appointment to final payment across various systems.

The outcome is a non-standardized set of processes that are time-consuming, manual, and possibly prone to error. Recent research estimates that because of complexity, physicians lose 17 percent of

Medicaid revenue to billing problems, compared with 5 percent for Medicare and 3 percent for commercial.¹ To identify opportunities within this ecosystem, we separated it into two components:

- **Claims processing:** The process of submitting, assessing, and adjudicating claims through the US healthcare ecosystem to determine payments to providers from payers, which are based on pre-negotiated rates, and from patients through copays
- **Prior authorization (PA):** The process by which payers determine the medical necessity of specific procedures before allowing physicians to provide the service

This chapter focuses on interventions within the structure of the current US healthcare system. This allowed us to identify opportunities in the near term without a substantial change. Other research examines systems such as a single-payer model, though recent literature has found that administrative spending savings from moving to a single-payer model may not be substantially greater than the potential savings in the current US healthcare system construct.²

3.1 CLAIMS PROCESSING

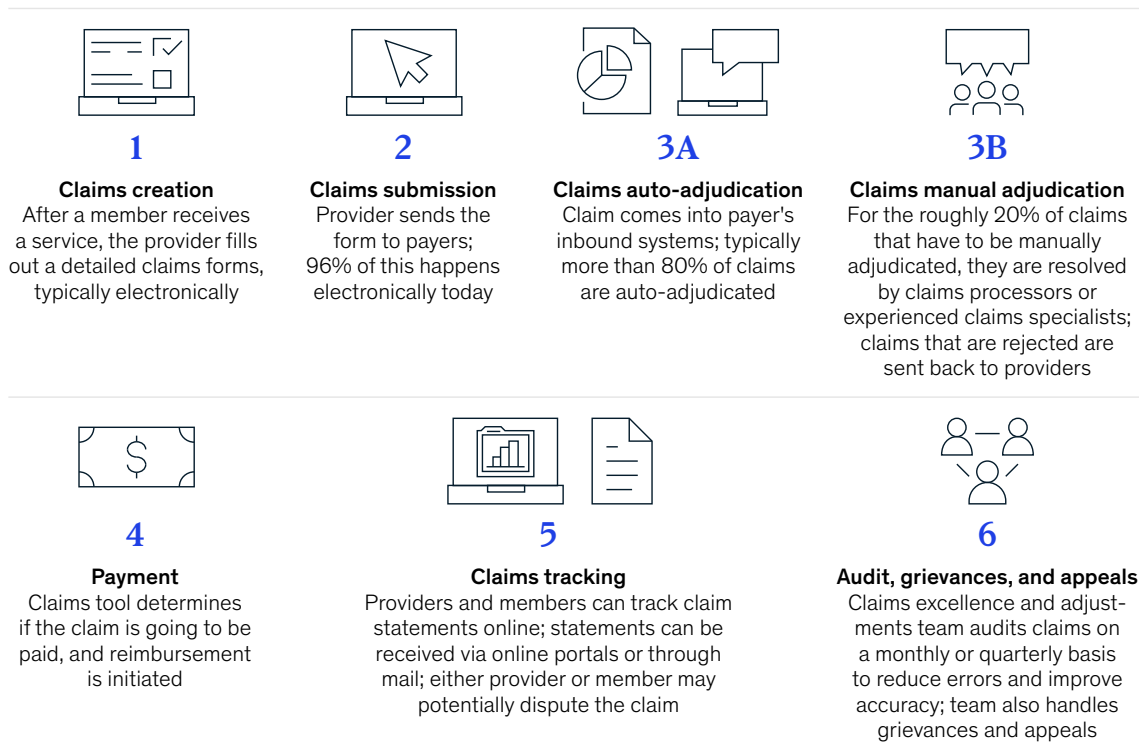
Definition and sizing

Claims processing in this report refers to the flow of claims starting after a medical service has been provided. As such, it would be after the PA portion of the financial transactions ecosystem. It begins when a claim is submitted by the provider after they provide a service and ends when the payment is either rejected by the payer or accepted, at which point payment is made to the provider (Exhibit 3.1).

Of the \$165 billion spent on claims processing, our key stakeholder groups represented \$105 billion—physician groups (\$40 billion), private payers (\$35 billion), and hospitals (\$30 billion). For physician groups and hospitals, these represent the

Exhibit 3.1

Current claims processing journey (illustrative)



Source: 2020 CAQH Index; Peter Orszag and Rahul Rekhi, "Real-time adjudication for health insurance claims," 1% Steps for Health Care Reform, February 2021, onepercentsteps.com; McKinsey Payer Operations Domain

major components of the "cost to collect" function and include areas such as claims submission and processing, patient accounting, and credit and collections. For private payers, this comprises the entire claims management team, including examiners that review claims, specialists that manage high-complexity cases, and grievance and appeals teams (see chapter 2 for more detail on these estimates).

Key opportunity areas

We identified the major pain points that have plagued payers, hospitals, and physician groups in the end-to-end claims submission and processing journey (Exhibit 3.2). This analysis revealed two themes: the presence of data inaccuracies and process inefficiencies within organizations, and a lack of consistent data definitions and an integrated claims process between organizations.

"Within" opportunity areas: In our experience, payers, hospitals, and physician groups struggle with incomplete and inaccurate provider and customer data within their own systems. This can result in claims errors that must be manually adjudicated, leading to unnecessary administrative spending. These stakeholder groups also struggle with complicated and inefficient internal processes that prevent the timely and accurate processing of claims. These challenges present a few specific within opportunities, including:

- **Complexity of products and associated rules:** A rise in the number and specialization of payer products, largely spurred by market competition, leads to an ever-increasing number of rules (for example, eligibility checks) that must be applied to corresponding claims in the adjudication process. Some of these are due to legacy

building upon legacy, but part of this is by design, as stakeholder groups attempt to better manage medical costs. This has been complicated by the growth of value-based payment models that have potentially separate rules. Thus, the greater the number and the more complex the business rules, the more likely any claim will need manual review. Additionally, the ability to “match” required documentation (for example, medical records, eligibility verification) can become more difficult when the rules themselves are complex, such as for dual eligible members.

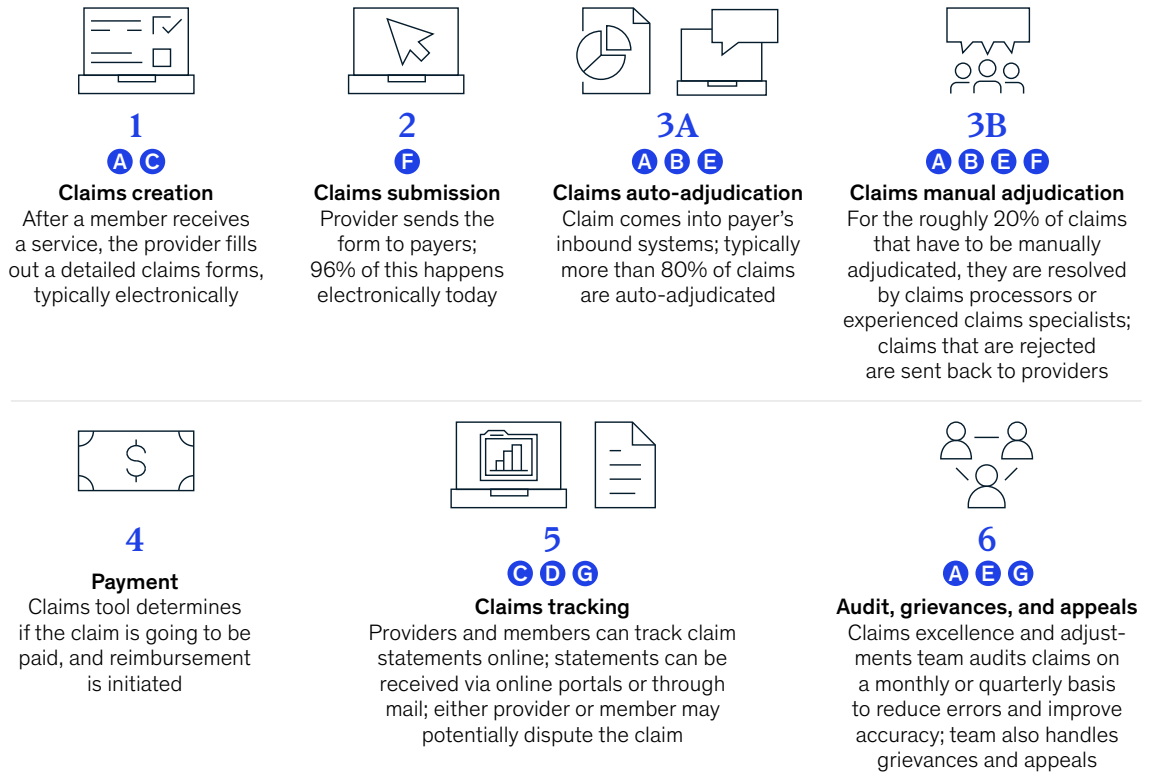
— **Poor data management and coordination:** Incomplete or inaccurate claims submission can lead to the failure of the auto-adjudication process, resulting in higher-cost manual edits. A common example is when payers record inconsistent data about the same customer across various contracts, including medical, dental, and pharmacy benefits. Each contract may have different information about that same customer. It may also ask for the same information in different ways, making it difficult to determine whether this is the same customer. Reasons for

Exhibit 3.2

Pain points along current claims processing journey (illustrative)

Pain points

- | | |
|--|---|
| A Complexity of products and associated rules | E Complexity of payer-provider contracts |
| B Poor data management and coordination | F Lack of consistent data definitions and supporting information |
| C Complex claims tracking process | G Unclear and inefficient claims payment tracking and recovery process |
| D Unclear Explanation of Benefits for members | |



Source: 2020 CAQH Index; Peter Orszag and Rahul Rekhi, "Real-time adjudication for health insurance claims," 1% Steps for Health Care Reform, February 2021, onepercentsteps.com; McKinsey Payer Operations Domain

There is a consistent gap in alignment and collaboration between payers and providers throughout the end-to-end claims workflow.

this include different forms used to record customer data or lack of communication between the various teams within the same payer that manage medical, pharmacy, dental, and other ancillary benefits. There are parallels to this situation in hospitals and physician groups as well. Such within inconsistencies can prove costly in terms of the additional labor hours needed to triangulate across different sources of data.

- **Complex claims tracking process:** Currently, more than 95 percent of claims are submitted by providers versus members who submit directly to payers; only 72 percent of claims status inquiries are electronic.³ Lack of transparency on payments can lead these providers to invest time telephoning payer call centers to investigate claims status. Payers reciprocally have to invest in call centers to answer those questions.
- **Unclear Explanation of Benefits for members:** Explanation of Benefits documents are intended to provide payers' members with an understanding of the fees for the services they received and whether the payer or the member owes payment. Jargon-heavy language and unintuitive presentation can make it unclear to a member whether documents received are explanations of what has already been paid or whether there is an additional balance owed. This issue becomes even more acute in high-deductible health plans. Furthermore, information from the provider may not be consistent with what is provided by the payer, causing further confusion for the member. The administrative burden of resolving the confusion through grievance and appeals teams can be costly to both payers and

providers, as well as disruptive for the member. The No Surprises Billing Act has begun to address these issues by requiring payers to provide advance cost estimates to members, called "advanced Explanation of Benefits."⁴

"Between" opportunity areas: There is a consistent gap in alignment and collaboration between payers and providers throughout the end-to-end claims workflow. The issues range from upstream complexity of payer-provider contracts, to differing data definitions and supporting documentation used by payers and providers, to misalignment on how to track and pay claims. This friction creates rework and requires repeat interactions between payers and providers to process a claim accurately. These issues present a few specific between opportunities, including:

- **Complexity of payer-provider contracts:** There is a proliferation of hyper-customized insurance products in the US market due to customers' demands for tailored benefits. This creates a need for contracting between payers and providers to support each customized product. For example, if an employer wants a certain set of doctors to be in-network for their employees, the payer must negotiate appropriate rates with those providers. This process will need to be repeated for every customized benefits package. That means that the same payer-provider combination may need to negotiate as many combinations of rates as there are customers for the payers. The administrative burden of negotiating, recording, and managing these contracts, especially making sure the claim is processed at the right reimbursement rate for the member, can be quite high for all involved.

- **Lack of consistent data definitions and supporting information:** There is often a lack of clarity and alignment on how providers should fill out and substantiate claims forms, especially given differing rules and expectations from various payers. This can lead to a burdensome back and forth between payers and providers to ensure they record the right information before a claim can be processed. A common example is missing medical records that are needed to validate the medical necessity of the service (examined as part of the PA process in chapter 3.2). Another example is when providers fail to complete claims forms because they may not understand which fields are required; the most frequently missed information on claims forms includes date of accident, date of medical emergency, and date of onset.⁵
- **Unclear and inefficient claims payment tracking and recovery process:** Payers, hospitals, and physician groups must often manage a fragmented, manual process of tracking claims and payments between each other. For hospitals, this is called the “cost to collect.” In our experience, hospitals spend about 2 to 3 percent of their annual revenue ensuring they receive the right payments and have well-timed cash flows coming in from payers. Payers similarly dedicate resources to their payment integrity function to check for fraud and abuse. Research shows that the health-care industry could reduce \$20 billion to \$30 billion in fraud and abuse annually.⁶

Known interventions

“Within” interventions (5 to 10 percent):

We catalogued known interventions that could save 5 to 10 percent of administrative spending on claims processing solely through within interventions. These are interventions that can be controlled and implemented by individual organizations. While these interventions roughly match one-to-one with the opportunity areas, the combination of interventions will depend on the pain points that an individual organization is most acutely facing.

For example, if one organization wants to reduce manual errors, they may choose to invest in the automation of downstream claims processes such as adjudication; another may choose the up-front simplification of products to reduce downstream complexity:

- **Simplify products offered:** For a payer, interventions that simplify the number of products could have two benefits: reducing the complexity of business rules—including the number of contracts between the same payer-provider pair—that must be applied to claims and increasing the proportion of claims that can be auto-adjudicated. Simplifying products, however, must be balanced against the wish to provide customized services to customers and to design products nuanced for various risk pools. While this intervention can be done by individual payers, we also explore a “seismic” intervention at an industry-wide level in chapter 8.
- **Streamline claims submission and communication process:** Interventions that payers can consider adopting include: creating a simplified provider platform for claims submission, supplementing claims with provider-friendly explanations and simple next steps, and providing push notifications to update providers on claims status.
- **Automate adjudication:** As noted in Exhibit 3.1, only about 20 percent of claims need manual adjudication, but they drive a sizeable savings opportunity. Payers can conduct single- and multivariable analyses of claims data to determine the most common causes about why a claim failed to process automatically. They can also use self-learning algorithms that filter claims in real time upon entering into their systems, using core elements of the data (for example, age, gender, diagnosis-related group codes, primary and secondary diagnoses) to identify cases that could have issues such as fraud. Providers can use automation to ensure a claim is as complete and accurate as possible before submitting it. They can do this by validating that a medical service is, in fact, cov-

ered under a patient's health benefits or checking that the total claim amount aligns with the total allowed amount under the patient's current policy.⁷

- **Clarify Explanation of Benefits:** Interventions by payers may include simplifying member-facing interfaces, such as offering a digital payment summary that allows members to immediately receive an explanation of their financial responsibility. They can also provide the Explanation of Benefits and next steps in easy-to-understand language through communication mediums tailored to member preferences—for example, text versus phone calls versus emails—and by using cleaner visuals to explain the flow of payments.

“Between” interventions (15 to 20 percent):

We also catalogued known interventions that could save 15 to 20 percent of administrative spending on claims processing solely through between interventions. These are interventions that require agreement and collaboration between organizations but not broader, industry-wide change. While these interventions roughly match one-to-one with the opportunity areas, the combination of interventions will depend on the most acute pain points that the payer-provider pair is facing. For example, one payer-provider pair may face issues around claims intake and could invest in provider portals to standardize that process; another set may use portals to standardize the claims tracking process instead. Further, several initiatives are underway that provide foundational support to these interventions. One example is the US Core Data for Interoperability (USCDI) program, which aims to create a patient-centered healthcare data set that specifies standards-based health data classes and elements to improve interoperability.⁸ Another initiative

is the Fast Healthcare Information Resource (FHIR), which is creating an internet-based approach to searching and exchanging healthcare information like search engines do with data in other industries.⁹

- **Improve data management and coordination:** Interventions here require a concerted effort by payers and providers to substantially upgrade their capabilities and technologies with regard to data. In our experience, one of the highest return-on-investment interventions includes maximizing the potential for digitalization of claims intake through provider portal improvements. These portals, generally built by third parties, allow providers to log into accounts for different payers and conduct activities such as searching for members' eligibility, submitting claims, and tracking claims status. Improving the ease of use of portals, including ensuring connectivity to electronic health records so that data do not have to be reentered, can further reduce hospital and physician group administrative spending. Other interventions include: standardizing language, definitions, and the terminology used in contracts for products and by claims teams, employing natural-language processing to scrub contracts and streamline interpretation when a non-standard claim comes in, and facilitating claims processing by reducing the number of clearinghouses. (See chapter 8 for a seismic intervention regarding a centralized, automated claims clearinghouse that reduces the need for individual payers, hospitals, and physician groups to launch their own initiatives.)
- **Improve coordination and clarity on claims-related communications:** Interventions could include collaboration between the claims and revenue cycle management

Provider portals, which are tools that help payers and providers with data management, can support easier tracking and recovery of claims.

teams of payers and providers to clarify language on their Explanations of Benefits, building a unified system that allows members to track the status of a claim, and simplifying member-facing interfaces.

- **Streamline claims payment tracking and recovery process:** Provider portals, mentioned above as tools that help payers and providers with data management, can also support easier tracking and recovery of claims. As claims are being processed, providers can use portals to track claims and identify any trending errors or problem areas that need attention. In addition, the portal could provide notifications regarding current claims status and expected payment data. Teams at the payer and provider could further extend this idea into an end-to-end solution for the providers' appeals process, including auto-validation and automatic notifications to providers on the status. While this could be a step forward, more administrative savings might come from direct interoperability between payers' and providers' systems to submit and process claims. This could lessen the burden on providers to log into multiple systems and submit each claim individually.
- **Align incentives between payer and provider through risk-sharing models:** In this intervention, payers and providers align on two areas: (1) the metrics they could monitor on quality of care and resulting patient outcomes, and (2) the most critical pieces of data that they would need to share to inform those metrics. This alignment could reduce the administrative burden on both sides of the relationship. Nonetheless, if each relationship has a differing set of metrics, it could increase complexity overall for the US healthcare system. Investments in data and analytics to support these new models may also be necessary. We acknowledge that doing this at an industry-wide level could have more impact (see chapter 8 for further detail), but given the current US healthcare system, one-by-one agreements are the more likely path.

3.2 PRIOR AUTHORIZATION

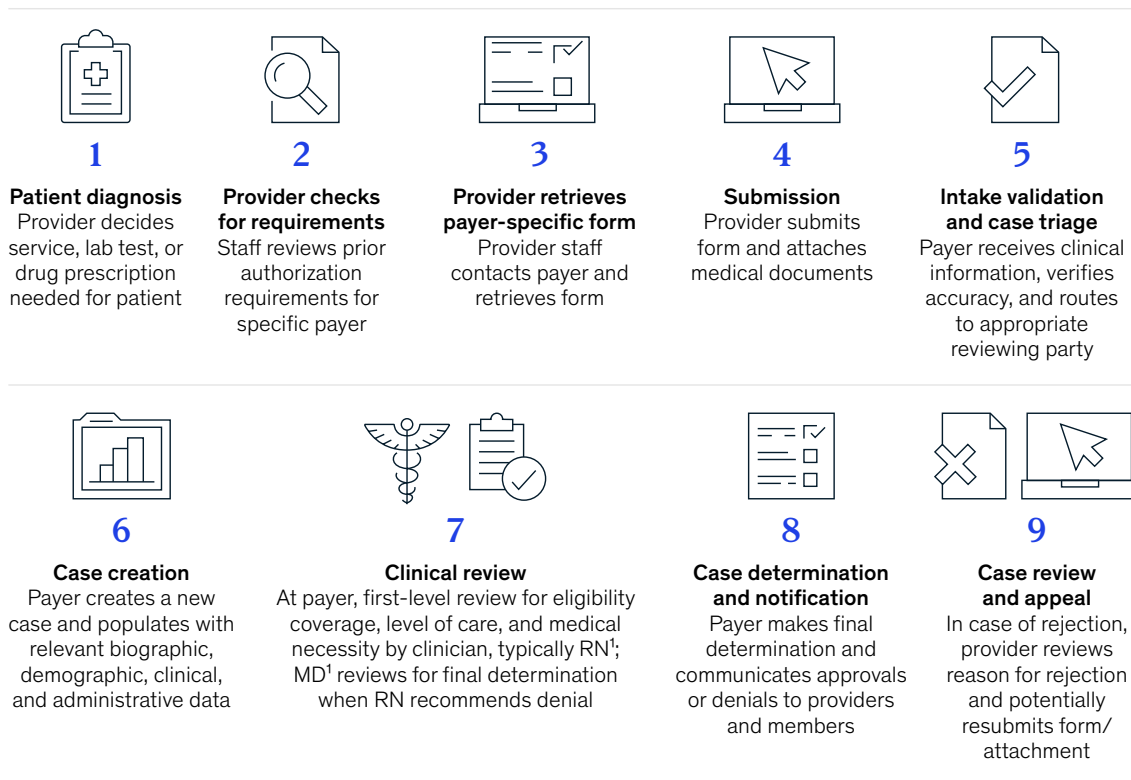
Definition and sizing

PA is a specific function within the medical management operations of payers and revenue cycle management functions of hospitals and physician groups. In the market-based US healthcare system, PA has come about as a check and balance between these stakeholder groups. Its primary goal is to assess the medical necessity and coverage of healthcare services and procedures according to established criteria or guidelines under the provisions of payer programs to prevent excess and unnecessary utilization. PA also could flag if newer, better treatments are available, improving the quality of care (for example, in evolving specialties such as oncology where the standards of care are being refined). PA plays an important role in the US healthcare system, so there will always be necessary administrative spending on this function.¹⁰

PA affects a small subset of procedures; for example, more than 90 percent of commercial enrollees are in plans that limit PA to less than 25 percent of medical services.¹¹ But PA remains a labor-intensive process. It starts when a physician determines that a patient needs a service, such as surgery, and contacts the patient's payer to ascertain if that particular service requires PA. The subsequent steps include payers checking on whether the procedure is medically necessary, providers attaching relevant documentation, and back-and-forth conversations to adjudicate the result (Exhibit 3.3).

Research has also shown that there are indirect costs of PA, such as physician burnout and employee turnover, perhaps resulting from the amount of paperwork providers are required to do.¹²⁻¹⁴ While we acknowledge this, we are focused on the direct, administrative spending associated with PA in this report.

Exhibit 3.3

Current prior authorization journey (illustrative)

¹ MD, medical doctor; RN, registered nurse.
Source: McKinsey Payer Operations Domain

Of the \$35 billion spent on PA, our key stakeholder groups represented \$30 billion—private payers (\$10 billion), hospitals (\$10 billion), and physician groups (\$10 billion). While we focus primarily on PA for medical services, there is potential for pharmacy benefit managers and pharmacies to reduce administrative spending in this area as well.

Key opportunity areas

There are three major pain points in the current PA journey (Exhibit 3.4).

- **Manual process:** PA is one of the least automated transactions in healthcare. About 21 percent of medical services PAs are electronic, compared to approximately 85 percent of eligibility and benefit verifications and 96 percent of claims submissions (Exhibit 3.5).¹⁵ Reasons for

this include the complexity of medical policies, lack of infrastructure supporting electronic submission of supporting clinical documentation, limited vendor options, number of web portals, and varying state laws.¹⁶

- **Lack of standardization:** The standard for sharing supporting medical documents for PA has not yet been established, leading to additional complexity in submitting PA requests.¹⁷
- **Effectiveness of PAs:** Given the high burden that PAs place on providers, one salient pain point involves ensuring that they are as effective as possible. This could include applying discretion when using PAs (for example, in targeted high-cost areas where treatments are still evolving) and where the possibility of denials being overturned is low.

Known interventions

“Within” interventions (0 to 5 percent):

The nature of PA requires payers and providers to collaborate to determine the value-added of various services. As a result, the savings that a single organization working alone could capture may be limited. Still, there are opportunities for individual organizations to reduce manual work by prioritizing which PAs are actually needed and triaging the ones that have the highest impact:

- **Sunset old PAs:** Many PAs are introduced to assess new treatments in areas where medical policies have not yet been formalized, requiring careful evaluation to justify the frequently high costs. However, as those treatments go through a normal

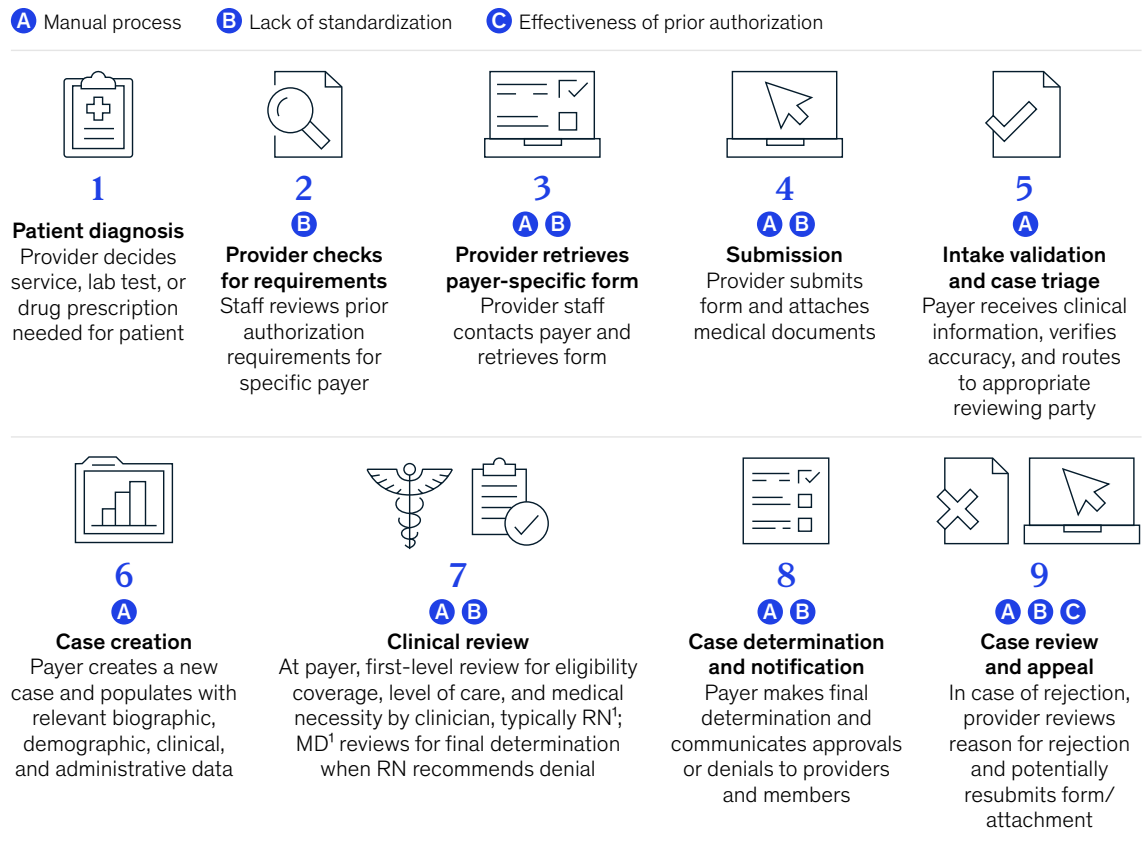
product lifecycle (for example, a branded drug losing its patent), codified PAs may not be revisited or reset to acknowledge this change. In our experience, there are a number of PAs that continue to be monitored but are no longer clinically relevant. This leads to unnecessary administrative spending for payers. Annual review and removal of PAs that are never denied can be quick wins that reduce the administrative burden of this process.

- **Prescreen PA using digital support:** Processing PAs for a payer is largely manual, using skilled labor such as doctors and nurses. In our experience, introducing a digital prescreening process based on clinical pathways could reduce the

Exhibit 3.4

Pain points along current prior authorization journey (illustrative)

Pain points

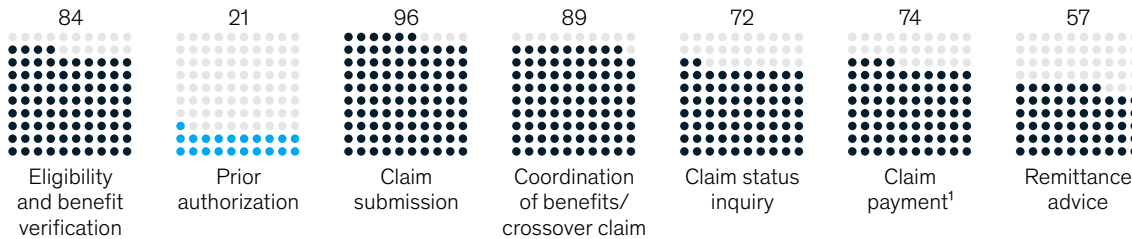


¹ MD, medical doctor; RN, registered nurse.
Source: McKinsey Payer Operations Domain

Exhibit 3.5

Electronic adoption levels across various claims workflow transactions

Percent of transactions that are electronic, 2020



¹ See chapter 8 for further exploration of adopting a centralized, automated claims clearinghouse.
Source: 2020 CAQH Index

amount of manual labor by separating PAs that are more common, whether for denial or acceptance. Furthermore, the data from the prescreening can provide payers with the ability to identify PAs to sunset or alter.

- **Increase proportion of automated PAs:** In our experience, interventions to automate PAs throughout the journey could lead to a 5 to 10 percent reduction in total PA spending for payers and providers. Currently, most PAs are handled manually; only about 21 percent are automated.¹⁸ A recent pilot run by Council for Affordable Quality Healthcare (CAQH), a healthcare non-profit alliance, and the Cleveland Clinic employed new PA operating rules, excluding attachments. The approach led to staff-time savings of 80 percent, or 12 minutes of processing time per PA.¹⁹ A 2021 study showed that 71 percent of experienced providers who implemented electronic PAs reported faster time-to-patient care; they reduced the time between submitting a PA request and receiving a decision from the payer by 69 percent.²⁰ Automation-based interventions such as these are still emerging. They require a set of enablers, including: robust infrastructure to support submission of medical documentation, adoption of automation technology by providers, investment by payers, change in workflow processes, and integration of health information.

“Between” interventions (10 to 20 percent):

Organizations could see 10 to 20 percent savings on their PA spending through two primary between interventions that help address pain points involving manual work and that allow them to be more effective in applying PAs to targeted procedures and services:

- **Align jointly on PA criteria:** Many times, friction between payers and providers is created from differing perspectives on criteria for PA. Some interventions include: prealigning on medical necessity criteria for procedures and services where third-party standards are not available, or identifying PAs where denials are frequent and jointly addressing the root causes (for example, when a PA consistently has missing documentation, update what documents are required).²¹
- **Conduct targeted “gold carding”:** Gold carding is an arrangement between a payer and select providers to eliminate or reduce PA requirements for specific services, which simplifies administration for both sides. To operationalize this intervention, advanced analytics can help tailor gold-carding approaches to specific specialties and regions. For example, gold carding based on the providers’ adherence to evidence-based clinical guidelines can help lower administrative spending while keeping clinical outcomes constant. Our experience shows that gold carding can save 5 to 10

percent of total PA spending for payers and providers. There is some momentum in US healthcare to expand gold carding. For example, in June 2021, the Texas House of Representatives passed a bill allowing physicians to earn “gold card exemptions” based on their track record.²² Because gold carding is still an emerging intervention, there are several considerations for implementing it successfully. In our experience, there is growing acknowledgment that gold carding will be most successful when providers are in two-sided risk arrangements and thus jointly incentivized with payers to both manage spending and

improve quality. Also, payers would likely need a high share of a practice’s patients to realize the full savings. Another concern is that larger providers could be advantaged over smaller providers to meet the necessary conditions for gold carding, given greater resources.²³ A suboptimal outcome would be if the administrative savings from gold carding were outweighed by significantly increased medical spending. However, in our experience, there are enough data on provider behavior that could help to implement gold carding in targeted ways and still achieve net-positive savings for the US healthcare system.

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- ² Arnold Milstein et al., “Reducing administrative costs in US health care: Assessing single payer and its alternatives,” *Health Services Research*, 2021, Volume 56, Number 4, pp. 615–25, doi.org/10.1111/1475-6773.13649.
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- ¹⁵ CAQH Index, “2020 CAQH Index: Closing the gap: The industry continues to improve, but opportunities for automation remain,” Council for Affordable Quality Healthcare, 2021, caqh.org.
- ¹⁶ CAQH Core, “Moving forward: Building momentum for end-to-end automation of the prior authorization process,” Council for Affordable Quality Healthcare, 2019, caqh.org.
- ¹⁷ CAQH Core, “Moving forward: Building momentum for end-to-end automation of the prior authorization process,” Council for Affordable Quality Healthcare, 2019, caqh.org.
- ¹⁸ CAQH Index, “2020 CAQH Index: Closing the gap: The industry continues to improve, but opportunities for automation remain,” Council for Affordable Quality Healthcare, 2021, caqh.org.
- ¹⁹ Tim Kaja, April Todd, and Susan Turney, “Standards subcommittee meeting: Hearing on request for the National Committee on vital and health statistics (NCVHS) review of CAQH CORE operating rules for federal adoption,” Council for Affordable Quality Healthcare, August 2020, ncvs.hhs.gov.
- ²⁰ “New analysis shows benefits of electronic prior authorization for patients and providers,” America’s Health Insurance Plans, March 24, 2021, ahip.org.
- ²¹ Wendy Warring and Lauren Bedel, “Streamlining prior authorization: Final report & recommendations,” Network for Excellence in Health Innovation, September 2021, nehi-us.org.
- ²² “Governor approves bill to reduce prior authorization hassles,” Texas Medical Association, last updated June 30, 2021, texmed.org.
- ²³ Wendy Warring and Lauren Bedel, “Streamlining prior authorization: Final report & recommendations,” Network for Excellence in Health Innovation, September 2021, nehi-us.org.

CHAPTER 4

Industry-agnostic corporate functions

Industry-agnostic corporate functions comprise back-office, non-clinical tasks that are present in all industries, such as human resources and finance. In healthcare specifically, they are the largest of the five functional focus areas, with \$375 billion in annual administrative spending (or 39 percent of total administrative spending). Low levels of efficiency and effectiveness are salient problems that manifest themselves in a high proportion of automatable tasks that are currently manual and prone to errors (for example, creation of financial reports or creating a single source of truth about vendor spending across finance, procurement, and compliance teams). Interventions to address these problems include traditional operational excellence levers, such as demand management, lean process redesign, and automation. There are also next-generation interventions to build “functions of the future” by using new technologies and capabilities such as analytics and cloud computing to support faster decision making and extract sharper insights (for example, using data analytics in human resources to improve career development and retention). All of these are “within” interventions and could deliver \$95 billion in annual savings.

In all industries, there are certain back-office administrative functions that enable an organization to operate.

These are generally referred to as corporate or operational functions. For healthcare organizations, many of these functions are industry-agnostic; another group represents industry-specific operations. In this chapter, we will focus on industry-agnostic corporate functions, such as finance and human resources (HR).

New technologies such as automation and digitalization have transformed these corporate functions in other industries, delivering the next wave of productivity and savings while also improving customer experience. For example, in banking, new technologies could create an additional \$1 trillion of value.¹ Further, 60 percent of financial services leaders stated their organizations have used at least one new technology, including robotic process automation (36 percent), virtual assistants (32 percent), and machine learning techniques (25 percent).² These advances also highlight two other important hurdles that organizations are overcoming: how to more effectively manage handoffs between person and machine and how to put off or skip typical process redesign or reengineering in favor of automation.

To date, this evolution has largely not been realized in healthcare. Recent research highlights a substantial opportunity for automation among payers and providers.^{3,4} Capturing these savings will depend on an organization's ability to scale and coordinate automation across the enterprise, while also finding ways to reskill the workforce into higher-productivity roles.

Definition and sizing

Of the \$375 billion spent on industry-agnostic corporate functions, our key stakeholder groups represented \$250 billion—hospitals (\$115 billion), physician groups (\$90 billion), and private payers

(\$45 billion). For both hospitals and physician groups, this represented roughly 45 percent of their total administrative spending, driven by corporate functions such as HR, finance, accounting, and IT. Industry-agnostic corporate functions accounted for about 25 percent of private payers' total administrative spending, much of which comprises similar back-office functions (see chapter 2 for more detail on these estimates).

Key opportunity areas

Low efficiency and effectiveness are a challenge to healthcare organizations' industry-agnostic corporate functions. Healthcare has been slow to adopt traditional levers to address administrative spending in corporate functions, such as demand management and lean process redesign, and it has also lagged behind other industries in automation.^{5,6} For example, in finance, auditing expense reports or vacation time is a manual and inefficient process in many healthcare organizations. In other industries, organizations have been able to implement algorithms to cross-check expense reports against travel and personnel data, or systems to compare declared vacation days with badge swipes and computer-usage data. Some organizations have also redesigned employee activities and organizational structures to take advantage of worker capacity freed up by automation.⁷

The automation potential of technologies such as robotic process automation, machine learning, smart workflows, or natural language processing is substantial. Across industries in HR functions, there is about a 22 percent automation potential, with some subfunctions, such as time collection, attendance, and record keeping, showing more than 30 percent potential. In IT, there is about a 22 percent automation potential, with all subfunctions having 20 to 30 percent potential.^{8,9}

Known interventions

“Within” interventions (20 to 30 percent): To address these key opportunity areas, we catalogued known interventions. These could reduce administrative spending on industry-agnostic corporate functions by 20 to 30 percent, using solely within interventions. Individual organizations can achieve much of these savings, but some potential gains can be unavailable to smaller organizations because of limited economies of scale. However, the more recent entrance of vendors that offer these capabilities to payers and providers has created partnership opportunities that decrease the necessary scale. As a result of this partnership model, more healthcare organizations are now able to pursue the interventions below, regardless of their size:

- **Promote operational excellence using traditional levers:** For corporate functions, traditional levers to capture value that have been proven in other industries (Exhibit 4.1) include:

demand management to remove low-value activities, smart sourcing that procures resources most efficiently, lean process improvement through redesign and workload balance, organizational and governance changes that align the performance of teams with the organization’s vision, consolidation of support services to create scale, and automation to improve the quality of service and the precision of outcomes.

- **Build for “functions of the future”:** Healthcare is starting from a deficit in terms of automation in industry-agnostic corporate functions. This also creates an opportunity to jump ahead and bring industry-agnostic corporate functions into the next generation. For example, a traditional function such as HR could be reimagined to address the strategic needs of the business and the changing nature of the workforce. This could mean building an analytics capability within HR to mine data to hire, devel-

Exhibit 4.1

Traditional levers for operational excellence in corporate functions

Example initiatives by lever



Source: McKinsey Payer Operations Domain

op, and retain the best employees.¹⁰ Skills-focused sourcing is another opportunity, where HR professionals are supplied with the analytical tools and relevant data necessary to identify temporary labor for their organization's changing needs. This may be a critical time saver and source of efficiency for providers that increasingly rely on agency staffing. Finally, the growth of cloud-based technology

could allow smaller organizations to implement these interventions without substantial capital investment in new technology.

“Between” interventions (not applicable): Given the internal nature of industry-agnostic corporate functions, the majority of savings are within organizations, not between different stakeholder groups.

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- ¹ Suparna Biswas, Brant Carson, Violet Chung, Shwaitang Singh, and Renny Thomas, “AI-bank of the future: Can banks meet the AI challenge?,” September 19, 2020, McKinsey.com.
 - ² Suparna Biswas, Brant Carson, Violet Chung, Shwaitang Singh, and Renny Thomas, “AI-bank of the future: Can banks meet the AI challenge?,” September 19, 2020, McKinsey.com.
 - ³ James Manyika, Michael Chui, Mehdi Miremadi, Jacques Bughin, Katy George, Paul Willmott, and Martin Dewhurst, “A future that works: Automation, employment, and productivity,” January 2017, McKinsey.com.
 - ⁴ Brandon Carrus, Sameer Chowdhary, and Rob Whiteman, “Making healthcare more affordable through scalable automation,” September 16, 2020, McKinsey.com.
 - ⁵ James Manyika, Michael Chui, Mehdi Miremadi, Jacques Bughin, Katy George, Paul Willmott, and Martin Dewhurst, “A future that works: Automation, employment, and productivity,” January 2017, McKinsey.com.
 - ⁶ Brandon Carrus, Sameer Chowdhary, and Rob Whiteman, “Making healthcare more affordable through scalable automation,” September 16, 2020, McKinsey.com.
 - ⁷ Frank Plaschke, Ishaan Seth, and Rob Whiteman, “Bots, algorithms, and the future of the finance function,” January 9, 2018, McKinsey.com.
 - ⁸ Alexander Edlich, Fanny Ip, and Rob Whiteman, “How bots, algorithms, and artificial intelligence are reshaping the future of corporate support functions,” November 15, 2018, McKinsey.com.
 - ⁹ When deploying these levers, especially automation, it is important to guard against algorithmic bias that could negatively affect equity or access for vulnerable populations.
 - ¹⁰ Asmus Komm, Florian Pollner, Bill Schaninger, and Surbhi Sikka, “The new possible: How HR can help build the organization of the future,” March 12, 2021, McKinsey.com.

CHAPTER 5

Industry-specific operational functions

Industry-specific operational functions are back-office, non-clinical tasks that are generally only found in healthcare, such as clinician credentialing and management of medical records, or that have health-care-specific nuances, such as underwriting or broker-based sales. They are the third largest of the five functional focus areas, with \$135 billion in annual administrative spending (or 14 percent of total administrative spending). Similarly to industry-agnostic corporate functions, they suffer from low levels of efficiency and effectiveness, for example labor-intensive, customized processes to validate and credential providers. That is the case because these healthcare-specific functions have not received as much attention regarding automation or adoption of new technologies. Interventions include using predictive analytics to build “smart services,” for example ones that use self-learning algorithms to guide payers’ members to provider options that best fit them. Other interventions include making foundational data investments—for instance, building data lakes that link disparate data sources, such as claims, customers, and contracts. All of these are “within” interventions and could deliver \$30 billion in annual savings.

As discussed in chapter 4, healthcare organizations are supported by a set of administrative back-office functions that enable them to operate.

These are generally referred to as corporate and operational functions. Although many of these functions are industry-agnostic in healthcare, others focus on healthcare-specific tasks. In this chapter, we will focus on industry-specific operational functions, such as enrollment and billing, quality reporting, underwriting and actuarial, and clinician credentialing.

In most cases, healthcare organizations suffer from heavy manual work that results in low reliability and inaccurate outputs. Take underwriting, which is one of the most strategic operational capabilities for payers. This unit determines the premium rates for different customers based on customer-specific factors, such as size, mix, and utilization; the strength of the payer's network with providers, as well as its ability to route members to specific services; and macroeconomic factors, such as inflation. Because much of the data collection and analysis for underwriting is still manual, payers have been unable to employ new technologies such as predictive analytics, which generates pricing tailored to each customer (Exhibit 5.1). This represents a problem in both efficiency and effectiveness that results in unnecessary administrative spending.

Definition and sizing

Of the \$135 billion spent on industry-specific operational functions, our key stakeholder groups represented \$90 billion—private payers (\$50 billion), hospitals (\$20 billion), and physician groups (\$20 billion). For payers, this represented about 28 percent of their total administrative spending, driven by areas such as underwriting and pricing, broker-based sales, membership and billing, and clinician credentialing. For hospitals and physician groups, these

functions represented 10 percent of total administrative spending and manifest themselves in functions such as medical records, non-clinical provider-specific IT, and quality management (see chapter 2 for more detail on these estimates).

Key opportunity areas

An example of an industry-specific operational function with high opportunity for automation is enrollment and billing. In our experience, this function has an automation potential of approximately 25 percent. The function is the first step for payers to enter new customers into their systems, but it still relies heavily on manual data entry. For example, Small Groups (employers with less than 50 employees), Individual, and Medicare Advantage members are typically enrolled and configured through paper processes, which then require manual entry. Furthermore, paper- and fax-based enrollment processes often have no tracking, confirmation, or status updates. So, communications between the payer and the customer are routinely delayed, leading to holdups in setting up coverage. This can also make coordination more difficult between teams within a payer, for example, a contracts team that needs information about the members being enrolled to finalize documentation.

Known interventions

“Within” interventions (20 to 30 percent): To address these key opportunity areas, we catalogued known interventions that could save 20 to 30 percent of administrative spending on industry-specific operational functions using solely within interventions. Much of these savings can be achieved by individual organizations, either through direct investments in technologies or partnerships with at-scale vendors. The interventions listed below include both traditional levers, which apply as much to industry-specific operational functions as they do to

industry-agnostic corporate functions (see chapter 4), and newer interventions, such as smart services, that have become available to healthcare organizations with the introduction of new technologies.






- **Promote operational excellence using traditional levers:** As laid out in chapter 4, the levers that can improve industry-agnostic corporate functions can be applied for many industry-specific operational functions.
- **Build smart services:** Interventions that use predictive analytics to aid decision making can have an impact in administrative settings. In the member engagement process, predictive analytics can “smarten” navigation by guiding members to best-fit options,

supporting them with chatbots to answer frequently asked questions as they weigh their options, deploying self-service tools (for example, guided portals) for follow-ups, and using analytics-based agent coaching tools for personalized support. In addition to direct member-facing interventions, smart back-office interventions include using optical-character-recognition platforms to rapidly digitalize forms and cut down processing time, automating data extraction from digital forms utilizing natural language processing or robotic process automation tools, and embedding workflow tools with reporting capabilities to provide status updates. Post-enrollment, interventions include enabling digital and voice assis-

Exhibit 5.1

Evolution of underwriting as a “smart” function (illustrative)

Underwriting example

		Common pain points	Example “smart” solutions
1 Data gathering		<ul style="list-style-type: none"> • Multiple database platforms to gather data • Manual scrubbing 	<ul style="list-style-type: none"> • Standardized data intake forms • Automated data-gathering process using optical-character-recognition technology and robotic process automation
2 Rating/quoting		<ul style="list-style-type: none"> • Fragmented rating engine (eg, over 5 rating agencies) • Highly manual work 	<ul style="list-style-type: none"> • Automated processes where underwriters manually log, summarize, and transfer data across systems • Eliminated learning curves between specialized underwriters who perform specific tasks
3 Rate release to sales and negotiation		<ul style="list-style-type: none"> • Lack of standardized workflows • Lack of clear goals or incentives for underwriting 	<ul style="list-style-type: none"> • Provided connected experience for agents/underwriters, sales associates, administrative supports, and billing to work on the same process with role-relevant views, rules exposed within/called by electronic processes, and automated reports
4 Post-sale implementation		<ul style="list-style-type: none"> • Accountability issues when collaborating with billing and other teams • Underwriters burdened by administrative tasks 	<ul style="list-style-type: none"> • Developed capacity planning capability against forecasted case volume
5 Performance tracking		<ul style="list-style-type: none"> • Lack of centralized solution • Lack of consistency • Lack tracking of critical metrics 	<ul style="list-style-type: none"> • Improved visibility of underwriting data between teams through a common dashboard functionality • Integrated with a knowledge library to provide guidance on resolving edits and processing accounts/cases

Source: McKinsey Commercial Payer Analytics Domain

tants to onboard and educate members about benefits and developing multiple formats for identification cards (for example, physical, digital, and biometrics). In our experience, one Medicare Advantage payer was able to move from less than 25 percent paper-based enrollment to 90 percent digital enrollment, reducing the total processing time for an application from 25 minutes to five minutes. To do this, the payer built a digital enrollment platform that used techniques such as auto-population of known fields to eliminate manual work (for example, name of city once zip code was filled in), video guides for members to self-enroll, and multichannel access to the platform, including voice-enabled intake from cell phones.

- *Empower a function through foundational data investments:* Healthcare organizations may lack: foundational data liquidity, or data that are stored in similar formats and easily accessible; interoperability, or data that can

“speak to each other” across systems; and data-driven insights, or integrated data that aid decision making. As shown earlier in this chapter, payers’ underwriting functions may be too manual and complex from start to finish (Exhibit 5.1). In our experience, one payer addressed this issue by investing in a cloud-based data lake that houses all customer, contracts, and claims data and links them through common data dictionaries and standardized identifiers (for example, using “ABC” instead of “ABC Rx” for the name of a prescription drug). This investment resulted in needing less time to model personalized agreements with customers and lower error rates, leading to a 40 percent reduction in the time it took to formalize a customer deal.

“Between” interventions (not applicable):

Given the internal nature of industry-specific operational functions, the majority of savings are within organizations and not between different stakeholder groups.

CHAPTER 6

Customer and patient services

Customer and patient services comprise tasks that address questions and concerns expressed by payers' customers (members, hospitals, and physician groups) and providers' customers (patients). These services are increasingly moving to digital channels, such as self-service websites and applications, but much of this work in healthcare still occurs through phone calls. This is a smaller area of spending, accounting for \$80 billion in annual administrative spending (or 9 percent of total administrative spending). Salient pain points include a high volume of customers that have questions about billing or services rendered, as well as process complexities such as multiple routings to answer a question. "Within" interventions could create savings by reducing volume upstream through issue resolution, reducing call times downstream by using artificial intelligence that can address problems before a live agent is needed, or outsourcing to specialized vendors. "Between" interventions rely on payers, hospitals, and physician groups to collaborate by sharing unified communications (for example, a list of in-network physicians or clearer Explanation of Benefits) on integrated customer-facing platforms. These interventions could deliver \$20 billion in annual savings.

Customer and patient services reflect activities and processes that let customers ask questions and express concerns.

These have largely depended on call centers, but there is increasing reliance on digital and self-service applications. In healthcare, the definition of “customer” is complex; for payers, services need to be provided to members and providers, and for providers, services need to be provided to patients.

The type of calls and touchpoints in the healthcare industry differ in complexity and duration. For example, most patients call providers with questions about basic logistics, such as appointment scheduling or whether they accept a new insurance coverage, or with simple medical questions about issues such as interpretation of lab results or medication side effects. Similarly, for payers, a large number of questions are related to tactical logistics such as benefits verification or billing. However, there are patients with complex needs that are more likely to require greater engagement, including speaking to a human being. So, payers and providers can be expected to spend a certain baseline amount on customer and patient services.

Across industries, customer service is undergoing disruption. Customer expectations are changing and reshaping what “good” means. Expectations are rising: first-contact resolution and knowledgeable representatives are now seen as the hallmark of good service.¹ Customers familiar with the ease of transacting in other industries, such as in software or banking, are now seeking better service in healthcare. In addition, there are sizeable shifts in consumer behavior as multiple kinds of service emerge: 50 percent of customers now use three to five channels or endpoints for service and information across industries.² Finally, there is still value in live interactions despite the availability of other channels. As healthcare organizations try to respond to these market changes, they should also address

the digital divide, where the elderly or economically disadvantaged may not be able to access or use digital channels, raising questions about equity for all customers.

This customer service revolution is already taking place in industries such as telecommunications and retail. Certain leading healthcare organizations are also integrating many of these same new technologies and capabilities, as well as the same talent, into their customer and patient services. COVID-19 accelerated the transition to digital channels as payers, hospitals, and physician groups were compelled to move away from face-to-face interactions and build remote communication capabilities, whether digital or via phone.³ Yet, in our experience, these kinds of innovations remain the exception in healthcare because of underinvestment; the decentralized and subscale nature of operations across payers, hospitals, and physician groups; and lack of prioritization.

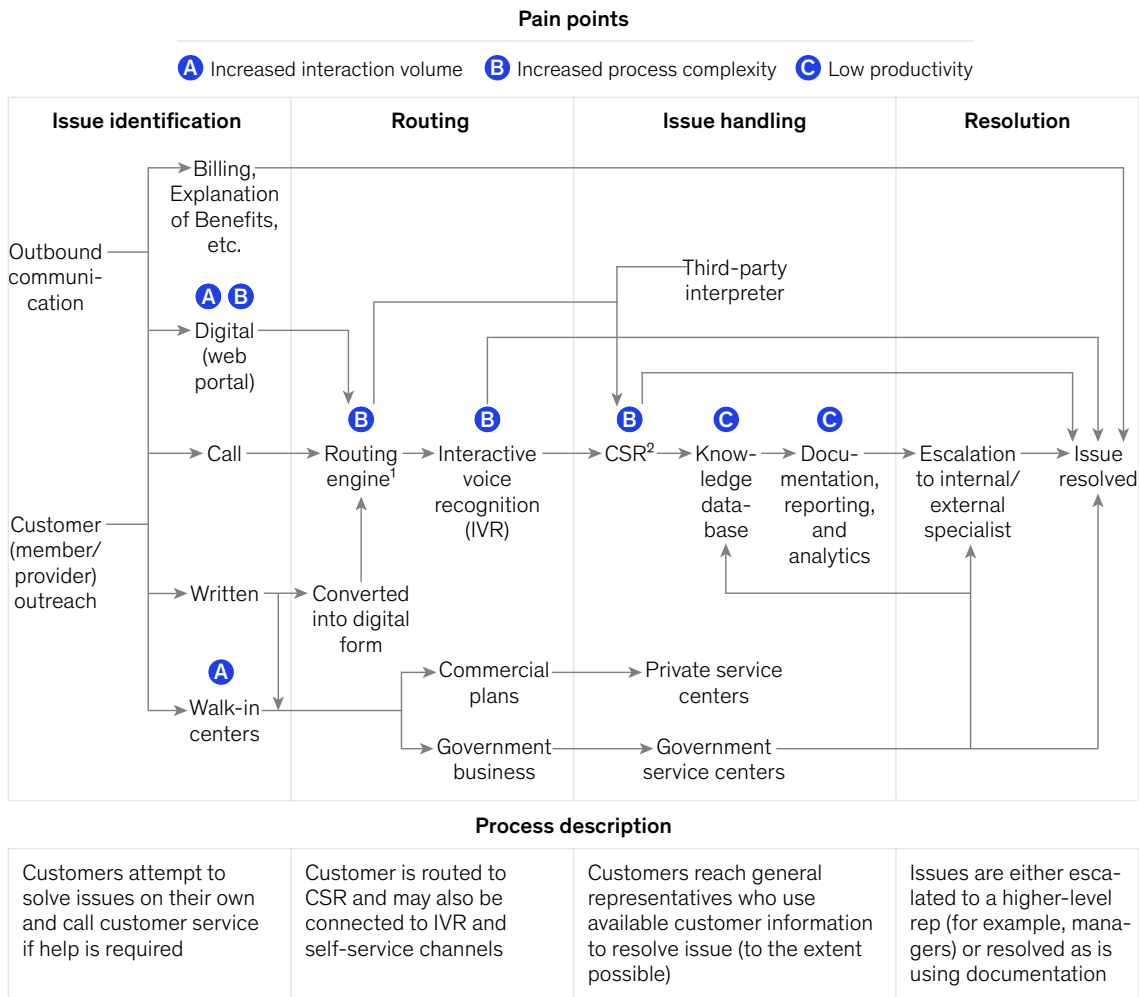
Customer and patient services also have an impact on customer experience, which can lead to customer attraction and retention. We do not focus on that in this report but acknowledge these second-order effects.⁴

Definition and sizing

Spending on customer and patient services across industries varies by the complexity of the business and the percentage of call center volume that is outsourced. From our research, businesses in complex and regulated industries such as healthcare, banking, and insurance spend 2 to 3 percent of total revenue on call centers, whereas businesses in less complex industries such as retail and telecommunications spend 1 percent or less of total revenue. This lower percentage is likely due to the simpler, more straightforward questions that are being asked and answered, and the ability to effectively outsource a substantial portion of the call

Exhibit 6.1

Pain points along current customer journey through payer's call center (illustrative)



¹ Routing engines distinguish between customers (ie, providers versus members) entering process.

² CSR, customer service representative. CSR can be involved in other processes such as utilization management and case management.

Source: McKinsey Payer Operations Domain

center volume. Organizations in more complex industries generally keep 20 to 40 percent of call center volume in-house.

Of the \$80 billion spent on customer and patient services, our key stakeholder groups represented \$55 billion—physician groups (\$25 billion), private payers (\$20 billion), and hospitals (\$10 billion). Among these stakeholder groups, customer and patient services represented the greatest portion of administrative spending for physician

groups (13 percent of total administrative spending), followed by private payers (9 percent), and hospitals (5 percent). For private payers, this includes spending on call centers that respond to members and providers, which are often staffed by call center representatives. For hospitals and physician groups, call center staff includes medical receptionists who help answer patient's questions about their care (see chapter 2 for more detail on these estimates).

Key opportunity areas

There is no typical customer service journey due to variations in the complexity of service needs (Exhibit 6.1). However, our experience shows that all journeys face similar challenges, generally driven by a lack of standardized data. This includes insufficient recording of customer history, incomplete linking of customer interactions across multiple calls and requests, missing documentation, and time-consuming manual work.

As a result, three main issues account for unnecessary administrative spending in customer and patient services:

- **Increased interaction volume:** Call demand has grown as call centers become the frontline of customer and patient services. Call centers are now the preferred method for customers to receive personalized service, rather than going in person or not asking questions at all. Two other factors are increasing the volume of interactions: growth in the Individual insurance segment and a greater focus on member satisfaction metrics in Medicare Advantage.
- **Increased process complexity:** Responding to service requests has become more challenging. Organizations have experienced call-routing management issues such as a large number of personalized matters not directed to the appropriate channel or staff. Also, they face service-time variability, including situations where customers with high needs are not immediately connected with the appropriate representative. A common example of a complex issue is patient scheduling. For example, rigidity in the system may force 15-minute appointments into 30-minute slots. In another case, the frontline call center staff may have incomplete information about patients' previous experiences

and spend substantial time gathering basic information (for example, billing history) rather than solving the actual problem.

- **Low productivity:** Poor layout, inefficient vendor management, and poor agent productivity contribute to low levels of productivity within many call centers. Some of the problems stem from outdated technology, underused staffing, overspecialized agents, and an unoptimized mix of full- and part-time employees. This is especially true for smaller hospitals and physician groups with subscale operations.

Known interventions

“Within” interventions (approximately 25 percent): We catalogued known interventions that could save 25 percent of administrative spending on customer and patient services by using solely within interventions. These are interventions that can be controlled and implemented by individual organizations. For example, organizations could save via upstream reduction of volume through issue resolution or via downstream reduction of call times through artificial intelligence (AI):

- **Reduce transaction volume through proactive issue resolution and interface improvements:** Interventions to reduce the volume of calls or touchpoints that are transactional (for example, questions that do not require human interaction, such as refreshing passwords or updating billing information) can take two forms: minimizing the need for interaction by fixing the root cause and making the information readily available on digital channels. The former can be done by using “SWAT” teams that conduct root-cause analysis on calls to identify the most common issues and ensuring they get fixed. This might include simplification of confusing communications on Explanation of Benefits documents if they form a sizeable pro-

Research has shown that digitalization of scheduling led to an increase in care continuity between patients and their primary care physicians.

portion of incoming calls. The latter can be carried out by updating organizations' websites and apps for easier usage, redirecting to self-service options during calls, and introducing technology such as predictive interactive voice response to resolve issues without an agent. In our experience, one US telecommunications organization reduced transactional call volumes by 75 percent and administrative spending by 20 percent by updating its website, making it easier to read bills, and improving user interface and experience functionality through more intuitive design.

In healthcare, research has shown that digitalization of scheduling led to an increase in care continuity between patients and their primary care physicians.⁵ However, this research also found greater adoption by younger, White, commercially insured patients. So, digitalization of this kind could have the unintended effect of widening the digital divide and worsening socioeconomic disparities in primary care access if not managed appropriately.

- **Improve handle time and issue resolution via AI:** This intervention is focused on using AI-based technologies to provide real-time coaching to call center agents. In our experience, a European healthcare organization used a technology that gives real-time guidance to customer representatives based on speech patterns and past observations; it improved customer and patient services and turnaround times. By listening in real time, the

technology provides guidance to the representative based on the speed, volume, and tone of the conversation. For example, it might nudge the representative to speak more slowly if his or her pace is faster than best practice, or it might give an “empathy cue” if it thinks the customer does not feel heard. By deploying this technology at scale, this European organization reduced average handle time by about 14 percent, increased the rate of issue resolution by about 6 percent, and raised employee engagement by about 63 percent. Further, customers perceived the representatives as more confident and empathetic and felt that their issues were being resolved.

- **Outsource to highly skilled vendors:** This intervention is to outsource call center volume to vendors who specialize in customer and patient services. However, outsourcing call centers should be evaluated within the context of customer and community preferences (for example, if the existing call center was a local employer) as well as overall considerations of brand.

“Between” interventions (0 to 5 percent):

We catalogued known interventions that could save up to 5 percent of administrative spending on customer and patient services by using solely between interventions. This type of intervention requires agreement and collaboration between organizations but not broader, industry-wide change. Although they are just emerging, these interventions aim to address information gaps between organizations in customer and patient services.

— **Build strategic payer-provider platforms to reduce demand:** Patients in the United States generally have to interact with two different types of entities—payers and providers—who often have different information about their care. Common examples include patients not knowing if the specialist their primary care physician refers them to is in network and seeing high out-of-pocket costs when payers decline to cover a service that their physician had recommended. A payer-provider platform can relieve much of the stress that derives from the amount of time it can take before a patient receives an answer. For example, providers can use such

platforms to refer to a digital list of in-network specialists and advise patients on whom they should see. Similarly, members could log onto this platform to understand exactly what their out-of-pocket costs might be for a service before receiving it. Organizations are beginning to see success with this type of intervention. For example, a regional payer and large health system are collaborating on a platform that streamlines customer communications to provide information such as the network status of physicians or expected out-of-pocket fees. By doing this, they expect to reduce administrative spending while improving customer satisfaction.

¹ State of Customer Care Survey, 2019.

² State of Customer Care Survey, 2019.

³ Oleg Bestsennyy, Greg Gilbert, Alex Harris, and Jennifer Rost, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?," July 9, 2021, McKinsey.com.

⁴ Jenny Cordina, Dan Jamieson, Rohit Kumar, and Monisha Machado-Pereira, "Improving acquisition and retention in Medicare," March 2016, McKinsey.com.

⁵ Ishani Ganguli et al., "Patient and visit characteristics associated with use of direct scheduling in primary care practices," *JAMA Network Open*, August 2020, Volume 3, Number 8, jamanetwork.com.

CHAPTER 7

Administrative clinical support functions

Administrative clinical support functions represent activities that can be customer-facing, including members and patients, and require some clinical expertise, but that are not related to hands-on care. Relevant functions include nursing administration (for example, staffing and scheduling of nurses) and case and disease management (for example, patient admitting and discharge). They account for \$105 billion in annual administrative spending (or 11 percent of total administrative spending). Salient pain points include the manual nature of tasks for nurse managers and case managers, such as scheduling nurse shifts or non-automated outreach to patients, and disconnected tools that govern major tasks, such as separate tools for scheduling and overtime management. “Within” interventions such as automation of those manual tasks and building application programming interfaces (APIs) to share data across tools could deliver \$15 billion in annual savings.

Administrative clinical support functions represent activities that can be customer-facing and require some clinical expertise but are not related to the hands-on care of patients. Historically, payers and providers have not sought savings from this functional focus area due to the clinical association of the work, but they are increasingly seeing opportunities for efficiencies without compromising access or quality.

Of the \$105 billion spent on administrative clinical support functions, our key stakeholder groups represented \$70 billion—hospitals (\$40 billion), private payers (\$20 billion), and physician groups (\$10 billion). Within these stakeholder groups, these functions represented the greatest portion of spending for hospitals (16 percent of total administrative spending), followed by private payers (10 percent) and physician groups (5 percent).

Within this functional focus area, we identified two specific subareas of administrative spending that predominantly involve nurses (Exhibit 7.1):

- **Nursing administration:** This is administrative spending on nursing management resources that are 100 percent dedicated to administrative activities such as staffing, float pool management, house supervision, patient placement, and transfers. Other elements of clinical administration, including management of staff such as nursing technicians, pharmacists, respiratory therapists, and dietitians, are not covered in this report because they often fall under clinical nursing.
- **Case and disease management:** This is administrative spending on resources to support coordination for high-need patients and members. For payers, case and disease management encompasses activities such as supporting these members as they navigate their care journey (for example, coordinating housing support and helping them find providers in their neighborhoods) and managing high-complexity diseases such as diabetes and congestive heart failure. For providers, aspects of disease management may be embedded in a range of care activities and

follow-ups. Case management is also seen as a critical component of revenue cycle management. It provides coordination and communication on admitting and discharge planning to ensure patients have the right care within and outside of provider settings. Other parts of revenue cycle management, including claims management and utilization management, are covered in chapter 3.

7.1 NURSING ADMINISTRATION

Definition and sizing

Nursing administration encompasses nurse managers (and select other roles) that are fully dedicated to an administrative role in both inpatient and outpatient settings. According to the *Journal of Nursing Management*, “the expectation is that nurse managers are adept at financial management, negotiation, staff recruitment and development, conflict resolution, technologic advancements, and leadership.”¹

Beyond nursing administration, hospitals and physician groups also hire nurses as case managers (chapter 7.2) or clinically-focused nurses (not covered in this report). The latter includes frontline nurses who spend most of their time on direct patient care and some portion on administrative activities (Exhibit 7.2).

Of the \$35 billion spent on nursing administration, our key stakeholder groups represented \$25 billion—hospitals (\$20 billion) and physician groups (\$5 billion). Private payers also hire nurses, but these are often covered under customer and patient services (chapter 6) or other administrative clinical support functions such as case and disease management (chapter 7.2).

In our experience, hospitals spend about 30 percent of revenue on nurses, of which 5 to 7 percent is spent on nursing administration. In our analysis, the \$20 billion hospitals spend on nursing administration would amount to 1.5 percent of total hospital revenue in the United States.² Physician groups rely less on nursing administration. They often call staffers who perform administration duties office managers or office administrators as they may wear multiple

hats. We found \$5 billion of administrative spending in physician groups, which is slightly less than 1 percent of total annual revenue (see chapter 2 for more detail on these estimates).

Key opportunity areas

Based on our experience, there are two key opportunity areas in nursing administration:

- **Manual nature of key tasks for nurse managers:** Most activities that nurse managers are responsible for, from patient flow management and budgeting to communications and nurse staffing, remain manual and labor-intensive. For example, with staffing, nurse managers have to manage an intricate web of constraints to build schedules for each day, taking into account patient acuity, staffing ratios, each nurse's travel and

vacation schedule, and availability of part-time versus full-time nurses. Staffing becomes especially burdensome given the volatility in patient flows, which can cause ebbs and flows in the supply and demand equation between patients and nurses.

- **Lack of integration across daily-use systems and tools:** Nurse managers often deal with an array of tools and systems to make decisions about staffing, budgeting, resource allocation, and quality control. Without a common set of data, definitions, and insights in one place, they have to manually connect information from one system to another. For example, they may manually note information from self-scheduling systems that identify shift availability for nurses and use that to assign nurses to patients on another portal.

Exhibit 7.1

Four components of care management

Component of care management	Example activities		For more information, see
	Payers	Providers	
Utilization management <ul style="list-style-type: none"> • Evaluation of the appropriateness, medical necessity, and efficiency of healthcare services and procedures according to established criteria under the provisions of a payer's program • Proactive processes such as discharge planning, concurrent planning, precertification, and clinical case appeals 	Running 24-hour nurse hotline; managing prior authorization	Managing referral requirements; working with care teams to ensure appropriateness of care being delivered	Chapter 3.2: Prior authorization
Case management <ul style="list-style-type: none"> • Method of managing the provision of healthcare to members and patients with high-cost medical conditions • Goal is to coordinate the care to improve continuity, increase quality of care, and lower spending 	Conducting outreaches and screening patients; coordinating social supports (for example, housing)	Developing care plans and coordinating discharge planning	Chapter 7.2: Case and disease management
Disease management <ul style="list-style-type: none"> • Process of reducing healthcare spending and improving quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition, through a system of coordinated healthcare interventions 	Sending quarterly mailings to patients identified with diabetes	Partially covered by case management and care plans	Chapter 7.2: Case and disease management
Not reviewed in this report			
Wellness <ul style="list-style-type: none"> • Resources and tools that help individuals understand their overall health status and take an active role in their personal health 	Rewards for members hitting goals	N/A	N/A

Source: McKinsey Payer Operations Domain

Exhibit 7.2

Breakdown of time spent by nursing staff across administrative and non-administrative activities in hospitals

Types of nurses	Total spending, \$ billion (percent of total nursing staff)	Percent of time spent on admin- istrative tasks	Total resulting administrative spending, \$ billion
Nursing administration: Nurse managers that focus on tasks such as staffing, float pool management, house supervision, and patient placement and transfers; not responsible for direct hands-on care of patients <i>Covered in chapter 7.1</i>	15–25 (5%–10%)	100%	15–25
Case managers¹: Nurses that manage coordination of high-need patients and communication tasks such as discharge planning but also have direct patient care responsibilities <i>Covered in chapter 7.2</i>	60–70 (15%–20%)	20%–30%	15–20
Clinical nursing: Frontline nurses who spend majority of their time on direct patient care but may have some administrative responsibilities <i>Not covered in report</i>	260–270 (~75%)	~10%	~30
Total spending on nurses²	345–365 (100%)		60–75

¹ Case management staff at hospitals are comprised of a 3:1 ratio between nursing staff and non-nursing staff (for example, clinical coordinators, discharge planners, and unit secretaries).

² Spending on nurses equals ~30% of total hospital revenue, which was estimated to be ~\$1.2T in 2019 by National Health Expenditure Accounts of the Centers for Medicare & Medicaid Services.

Source: Centers for Medicare & Medicaid Services; McKinsey analysis

Although these challenges are not new, a number of barriers have prevented the uptake of known interventions. Hospitals and physician groups that lack substantial scale generally find the cost required to implement new technologies prohibitive, further amplified by the long-term nature of realizing the savings. Also, nurses are often trained in a specific unit that has its own standards and procedures for using IT systems. Further, any administrative interventions that could have second-order impact on frontline caregivers tend to be pursued with careful consideration for the caregiver's bandwidth and potential disruption. Finally, certain activities, including critical review, have traditionally been kept manual given their heightened importance in patient care.

Known interventions

“Within” interventions (5 percent): We catalogued known interventions that could save about 5 percent on nursing administration by using solely within interventions. These are interventions that can be controlled and

implemented by individual organizations. In previous chapters, we identified interventions that could result in the need for fewer resources. That may not be the case here. While these known interventions could free up nurse managers' capacity so they can better focus on their tasks and support their staff through training and mentorship, they may not necessarily reduce the overall number of nurses an organization needs. This is due to both operational constraints (for example, staffing cycles) and regulatory or work-rule constraints such as California's Title 22 stipulations on nurse-to-patient ratios. However, the intangible benefits of the following interventions that reduce the manual work burden and boost productivity through technology may lead to financial savings within a few years through enhanced retention and nurse satisfaction:

- **Digitalize manual administrative activities:** Nurse managers spend much of their time on manual activities dealing with patient flows, staffing, and communication. There are proven uses of technology to add efficiencies in

these areas. For example, self-scheduling capabilities or predictive analytics can help better manage patient flow through optimal discharge timing or capacity planning.³ One caveat is that when these technologies are introduced, change management issues should also be considered in order for the interventions to take hold. For example, the new technologies should ideally fit within pre-existing workflows so nurse managers can naturally take them up in the course of business.

- **Enable management of larger spans:** Typically, nurse managers have large spans of control—the number of people that nurse managers look after—because the full-time equivalents (FTE) are generally homogeneous in terms of skills and expertise. Nonetheless, workforce management tools (for example, float pool visualizations and overtime prevention software) can help nurse managers in two ways. First, they could allow nurse managers to be more effective and efficient in their day-to-day tasks, permitting them to spend more time coaching and developing their teams. Second, they could make it easier to manage a large span. For example, workforce management tools can flag when individuals on their team have worked overtime. This might prompt a nurse manager to check in with individuals to assess burnout.

“Between” interventions (not applicable):

Given the internal nature of nursing administration, the majority of savings are within organizations, not between different stakeholder groups.

7.2 CASE AND DISEASE MANAGEMENT

Definition and sizing

Care management generally includes four components (Exhibit 7.1)—utilization management, case management, disease management, and wellness. In this report, we focus on case and disease management, which is defined as the coordination of support for high-need patients and members.

Of the \$70 billion spent on case and disease management, our key stakeholder groups represented \$45 billion—hospitals (\$20 billion), private payers (\$20 billion), and physician groups (\$5 billion). Hospitals and physician groups are predominantly focused on case management. They typically employ a 3:1 ratio of nurses to non-nursing staff, which includes clinical coordinators, discharge planners, and unit secretaries. This staff can be thought of as essential to revenue cycle management, as its activities intersect with clinical care and revenue cycle management teams (for example, discharge planning for appropriate length of stay, readmission prevention, and care plans for medical necessity). For private payers, this group includes nurses, social workers, and administrative staff. Their activities comprise conducting outreach and screening patients, assisting in coordination of social supports such as transportation and meals-on-wheels, and providing documentation support (see chapter 2 for more detail on these estimates).

Key opportunity areas

Payers, hospitals, and physician groups face similar challenges when it comes to administrative spending in case and disease management:

- **Manual, repetitive work:** Case and disease management are functions that have the most touchpoints with members (for payers) and patients (for providers). Given the “human” nature of the activities, there are many tasks that are done manually. However, many of these are often rules-based, repetitive work that could be automated. For example, payers and providers routinely reach out to members and patients for mundane items such as scheduling or public health offerings (for example, flu shots).
- **Disconnected tools and systems:** Over the last two decades, organizations have created many point solutions to support case and disease management for payers and providers.⁴ Such providers could find themselves managing a myriad of vendors within the realm of case management, from vendors focusing on particular aspects of population health management to those that support specific parts of revenue cycle management.

Known interventions

“Within” interventions (20 percent): We

catalogued known interventions that could save 20 percent of administrative spending on case and disease management by using solely within interventions. These are interventions that could be controlled and implemented by individual organizations and that may require changing pre-existing, in-organization work-flows such as scheduling or admitting through digitalization, technology upgrades, and performance management:

- **Digitalize and automate processes:** There are several steps that could be automated in the case and disease management workflow at both payers and providers. Reducing time to look up and confirm member or patient information is one example. Payers could automate tasks such as outbound dialing, case prioritization, and assignment of members to case managers. For providers, examples include admitting patients and registering outpatient visits.⁵
- **Integrate suite of tools and solutions:** Improving the usability of tools and making them interoperable can reduce the time taken to switch from system to system. In our experience, one Medicaid-focused payer implemented an enterprise-wide care management package that captured member engagement activities in one place and integrated that information with other systems such as utilization management software. The change led to reduced administrative spending through saved time and enabled the payer to offer personalized and real-time communications to its members. An example

for providers could be a portal that, possibly through electronic health records (EHRs), communicates care plans to patients and their caregivers, potentially reducing the need for patients to call or make in-person visits.

- **Improve operational discipline and ensure “top of license” practices:** Introducing standard operating procedures and metrics such as staffing ratios, case length expectations, and case graduation criteria can enhance the performance of case management resources. In addition, instituting a rigorous performance management culture could lead to better alignment on priorities and more effective use of time. Some organizations employ dashboards that measure key performance indicators (for example, case length, case graduation rates) and weekly performance reviews.

“Between” interventions (not applicable):

In the fee-for-service payment model, while case and disease management functions do require coordination across payers and providers (for example, payers may send their case managers with patients to monitor physician visits), there is less emphasis on joint execution. However, collaboration is increasing with value-based payment models as payers are delegating case and disease management responsibilities to providers. Further, in our experience, some payers are supporting providers to build the necessary capabilities such as managing social and medical support for a complex patient. Yet, given the low penetration of value-based payment models today, we did not focus on these between interventions in this report.

¹ Eloise Balasco Cathcart, Miriam Greenspan, and Matthew Quin, “The making of a nurse manager: The role of experiential learning in leadership development,” *Journal of Nursing Management*, May 2010, Volume 18, Number 4, pp. 440-7, doi:10.1111/j.1365-2834.2010.01082.x.

² National health expenditure data, Centers for Medicare & Medicaid Services, accessed September 17, 2021, cms.gov.

³ Lisa Massarweh, “Hospital staffing technology: Hazard and opportunity risks,” *Nursing Management (Springhouse)*, 2018, Volume 49, Number 11, pp. 48-53, lww.com.

⁴ Shubham Singhal, Basel Kayyali, Rob Levin, and Zachary Greenberg, “The next wave of healthcare innovation: The evolution of ecosystems,” June 23, 2020, McKinsey.com.

⁵ As this intervention evolves, there is likely an opportunity for a between intervention where payers and providers jointly agree to digitalize these processes. We have not seen this in practice at scale and so have not documented it in this report, but we acknowledge this could become another intervention in the future.

CHAPTER 8

Seismic interventions

“Seismic” interventions are different from “within” or “between” interventions in that they cannot be achieved by an organization operating on its own or with small-scale collaboration between payers, hospitals, and physician groups. In this chapter, we draw inspiration from other industries to identify a non-comprehensive list of seismic interventions that could accelerate administrative simplification in US healthcare. They take the form of technology platforms (for example, adopting a centralized, automated claims clearinghouse), operational alignment (standardizing medical policies), or payment design (modularizing product design). These interventions address spending in most of the functional focus areas and could deliver about \$105 billion in annual savings. Much of that total comes from simplifying the financial transactions ecosystem or streamlining duplicative healthcare processes such as state-specific clinician credentialing and payer-specific medical policy customization.

In previous chapters, we reviewed the opportunity by functional focus area for “within” interventions that individual organizations can control and implement and “between” interventions that require agreement and collaboration between organizations, but we did not examine broader, industry-wide change.

This chapter draws inspiration from other industries to examine a third type of intervention that we call “seismic.” These interventions are considered seismic because they cannot be achieved by an organization operating on its own or with small-scale collaboration between payers and providers. To understand the potential of these approaches for US administrative spending, we identified a few examples based on analogs. These interventions are not meant to be a comprehensive list nor offer a point-of-view on what is best, but they are intended to show what may be possible in US healthcare.

The chapter explores three broad themes: technology platforms (for example, adopting a centralized, automated claims clearinghouse), operational alignment (for example, standardizing medical policies), and payment design (for example, modularizing product design). Our research yielded seven seismic interventions that meet our “known” definition, which means they could be carried out in the next three years if there was agreement and collaboration from all necessary stakeholder groups (Exhibit 8.1). We estimated that these interventions could generate approximately \$105 billion of savings, or 11 percent of current administrative spending.^{1,2}

Technology platforms

Adopt a centralized, automated claims clearinghouse

Analogous to full adoption of a banking payment clearinghouse

The US healthcare system does not have a sole, centralized clearinghouse through which it manages claims payments. Payers instead may use a number of clearinghouses. A provider may send a claim to its contracted clearinghouse, which would then pass the claim to the payer’s clearinghouse. Multiple intermediaries could add complexity and cost to claims processing and increase the likelihood of delays and errors that could lead to customer service issues and business disruption.

We see the potential to incentivize more payers and providers to consider avenues such as the Automated Clearing House (ACH) network or processing networks for credit card payments. Focusing on the former, this national payment system connects all US bank accounts and facilitates the movement of money and information; it has already been adopted for use in healthcare payments. Over the past few years, the National Automated Clearing House Association (NACHA) has sponsored efforts to increase the use of the ACH for electronic funds transfer (also called ACH/EFT) in healthcare. As of 2020, about 74 percent of medical claims were paid through the ACH/EFT, up from 63 percent in 2018.³ By comparison, only 13 percent of dental claims were paid through the ACH/EFT in 2020, leaving the remaining 87 percent to be paid manually through paper checks.

There could be a meaningful return on investment when claims are paid through a system like the ACH. For example, transaction costs for payments through

There could be a meaningful return on investment when claims are paid through a system like the ACH.

an ACH compared to manual payments are seven times lower for private payers and three times lower for providers.^{4,5} Additionally, ACH fraud rates are the lowest across all payment types.⁶ Creating incentives—both bonuses and penalties—so that all healthcare claims payments go through a governing technology such as the ACH has the potential to materially reduce administrative spending on claims processing,

as experience in other countries and industries shows.⁷ Further, grounding a centralized platform with the proper supporting infrastructure, such as data integrity (for example, a single source-of-truth provider directory) and technology (for example, application programming interfaces with provider portals or claims submission and tracking capabilities), could enhance its usability and potentially increase adoption.

Exhibit 8.1

Seismic interventions and associated analogs

Example seismic interventions	Analog	Functional focus area impacted
Technology platform		
Adopt a centralized, automated claims clearinghouse: Set up an automated clearinghouse that systematizes payment between payers and providers	Banking payments clearinghouse	● Financial transactions ecosystem
Prioritize high-value interoperability use cases: Align stakeholders on high-value interoperability use cases and organize investments to scale necessary technology	Universal Product Codes in retail Sharing platforms for financial data	● Customer and patient services ● Administrative clinical support functions
Operational alignment		
Standardize medical policies: Apply uniform medical policies across all payers	Standardizing P&C insurance	● Financial transactions ecosystem
Standardize physician licensure: Eliminate state-specific requirements for physicians and allow all who meet federal requirements to practice across state lines	Standardized aviation licenses in the United States	● Industry-specific operational functions
Streamline quality reporting: Reduce number of quality measures to the highest-value subset and provide support for automated, digital methods of capturing data	Car safety measures and FICO scores	● Industry-specific operational functions
Payment design		
Modularized product design: Shift toward a modularized set of benefits packages for customers	Modularized offerings in enterprise software	● Industry-specific operational functions ● Customer and patient services
Adopt globally capitated models for segments of the care delivery system: Eliminate service-based payments from payers to providers by shifting all payments to a “capped” or fixed amount per patient	Evolution from cost-per-impression to pay-per-click for online advertising	● Financial transactions ecosystem ● Customer and patient services

Source: McKinsey analysis

Prioritize high-value interoperability use cases

Analogous to prioritization of a Unified Product Code in retail, which became a foundational use case from which other uses cases, such as tracking of products, were launched; another example is building sharing platforms for financial data that act as a consumer's single source-of-truth for specific use cases, such as credit cards, bank accounts, and loans

It is difficult to build a longitudinal view of a patient's health record over his or her life due to the fragmented nature of how patient data are stored and shared in the US health-care system. Investing in interoperability that is supported by an aggregated, real-time, and patient-centered database, while preserving privacy and patient confidentiality, could reshape how healthcare is organized, delivered, and managed in the United States. Through an administrative lens, interoperability could lead to reduced spending in several functional focus areas. One example of this includes cutting time spent on medical records matching in prior authorization (PA) by making medical records easily accessible and readable; another example is minimizing the need for call center touchpoints to answer customer queries on claims status by allowing members to have those data at their fingertips.

Interoperability is not a new idea, and there are numerous ongoing efforts on this front. These include: the Health Information Exchange of the Centers for Medicare & Medicaid Services (HIE CMS), an interoperability framework that offers a repository of patient information accessible to relevant providers; the Trusted Exchange Framework and Common Agreement (TEFCA) to enable the nationwide exchange of electronic healthcare information; the US Core Data for Interoperability (USCDI) effort that is aligning data definitions nationally; and continuing efforts to build a universal patient identifier.⁸⁻¹⁰ However, these technology-based initiatives have often been launched without clarifying the use cases they are meant to address.

To fulfill their promise, alignment may be beneficial on the most valuable use cases (for example, aggregated patient health records) across stakeholder groups. Once this prioritization is agreed upon, the existing interoperability approaches mentioned above could be reevaluated to ensure they are in support of those use cases.

To launch each prioritized use case, a trusted party, such as a well-regarded non-profit or a public-private consortium, could orchestrate and be seen as the leader of the effort. This could help patients feel comfortable adopting the innovation. Next, the appropriate rules to govern these use cases may need to be defined (for example, who has access to a patient record and who is responsible to update this record when new data are available). After this, the right technical partner can be chosen to build the enabling infrastructure (for example, a universal patient identifier and preference engines that record patients' choices on who can access their record). This structured process could help ensure that high-value use cases are built with the right buy-in up front and an enabling technology foundation to ensure full value capture of the administrative spending savings.

Operational alignment

Standardize physician licensure

Analogous to standardization of aviation licensure in the United States that allows pilots to fly across state lines

The federated nature of US physician licensure has resulted in a complex set of state-specific rules and requirements on where physicians can practice. Each state and territory has its own board for medical and osteopathic licensing, each of which has unique and specific requirements for physician licensure in that jurisdiction.¹¹ For example, while all states require physicians to show proof of graduation from an accredited medical school, others also ask for specialty-specific tests and coursework. This structure not

The Nursing Licensure Compact, agreed to by almost 35 states as of March 2021, allows nurses to have multi-state licenses.

only may create complications for physicians seeking to practice in other states (precluding cost-effective delivery models such as telemedicine), but it may also increase overall administrative spending at the national level. Standardizing credentialing has historically faced challenges due to concerns about lower quality care provision and de-emphasizing localized standards of care.¹² Also, even with standardization, physicians must still adhere to state-specific regulations, such as malpractice requirements.¹³

Proponents of standardization say that physicians already must meet criteria to become eligible to practice in any state—for example, graduating from an American Medical Association–accredited medical school, passing a comprehensive national medical licensing examination sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME), and meeting standards for work history and health status.^{14,15} In addition, there are already examples of standardized credentialing in the United States. The Nursing Licensure Compact (NLC), agreed to by almost 35 states as of March 2021, allows nurses to have multi-state licenses.¹⁶ Further, the Interstate Medical Licensing Compact or “Telemedicine Compact” (IMLCC) facilitates a legal agreement among 29 states to allow physicians licensed in one state to provide services through telemedicine in other states.^{17,18} Thus, administrative spending savings may result from lower credentialing spending for payers (currently \$15 billion annually). For providers, standardized physician licensing would potentially make cross-state care provision simpler, reducing administrative spending on the

multiple credentialing processes for the same physician. Further, such standardization could reduce constraints for start-ups that may provide lower-cost vended services to payers and providers.

Standardize medical policies

Analogous to standardization of property and casualty insurance through consistency of offerings—for example, the minimum amount that must be insured before a mortgage is allowed or standardized fault-determination methodology

Medical policies are guidelines written by payers to help providers determine if certain medical services are covered. These are generally published in provider-facing portals, with the intent of outlining how payers assess the medical necessity and appropriateness of a service. For example, a payer may require a step therapy where a patient must have received a generic version of a drug to lower cholesterol before a more expensive one can be prescribed. Complexity has grown over the last century, starting in the 1930s when the first set of medical policies were written.¹⁹ While the foundational requirements for medical policies are governed by states, each payer refines its own policies and continually refreshes them as medical research surfaces new treatments and insights. Commercial payers, which cover more than 175 million Americans, are not standardized, and thus, keeping pace with them may put substantial burden on hospitals and physician groups.^{20,21} (By comparison, Medicare has pursued national standardization for the diagnosis or treatment of an illness or injury.) While any standardization must be undertaken in compliance with competition laws, a range of potential approaches

could be considered, such as standardizing data requirements for PA.

Overall, there may be two scenarios in which hospitals and physician groups could benefit administratively from this intervention. First, they might spend less on PAs, as less nurse and physician time would likely be used in reviewing payer-specific medical policies. Second, they could spend less on claims, as there may be fewer follow-on denials and appeals.

Streamline quality reporting

Analogous to standardization of car safety metrics into a five-star system by the National Highway Traffic Safety Administration; another example is the creation of FICO scores as one high-value, standardized measure of credit risk

Over the past few decades, measuring the quality of care has risen in importance and become a core part of the “triple aim,” a framework developed by the Institute for Healthcare Improvement.²² The Centers for Medicare & Medicaid Services (CMS) originally created programs to assess quality by implementing payment and reporting incentives. These include both payer-facing measures (for example, CMS Star ratings) and provider-facing measures (for example, the Merit-based Incentive Payment System, or MIPS). Today, CMS requires reporting on more than 1,700 quality measures.²³ Research has shown that physicians spend 2.6 hours per week—the equivalent of caring for nine patients—reporting on quality measures; staff other than physicians spend 12.5 hours per physician per week on the same tasks, with the largest proportion (6.6 hours) by licensed practical nurses and medical assistants.²⁴ In an effort to simplify quality reporting, CMS introduced two different programs: in 2017, “Meaningful Measures” reduced the number of quality measures by 18 percent, and in 2020, “Meaningful Measures 2.0: Moving from Measure Reduction to Modernization,” continued the effort to require only the highest-value measures and to accelerate

modernization (for example, digitizing sources of data).²⁵ Further, physicians now have the flexibility to choose which measures they report: MIPS, for example, lets providers select six measures from a longer list.²⁶ Even with these changes, quality reporting could remain burdensome for providers, especially since the shift toward value-based payment models generally requires greater measurement of physician performance. Anticipating this shift, programs such as the Core Quality Measurement Collaborative (CQMC), a multi-stakeholder group effort working to develop quality measure sets by specialty and condition, are already prioritizing measures related to value-based payment models.²⁷ Overall, these examples highlight how administrative spending could be reduced through larger-scale collaboration between public and private payers on a short list of quality measures and standardized requirements to better enable digital collection of necessary data. For example, the CMS Star ratings program, which targets payers, is a helpful analog for streamlined quality measures within healthcare. It has narrowed a list down to roughly 40 measures that provide a standard method to evaluate the quality of a payer’s Medicare Advantage product.²⁸

Payment design

Modularize product design

Analogous to tiering of enterprise software packages—for example, modules for financial asset management, reporting, customer service, and business intelligence

One feature of the US healthcare system is the substantial variation in insurance product offerings. This variation is often viewed by employers (a payer’s customers) as a competitive advantage in recruiting employees as well as meeting the needs of their workforce. However, not all customers place the same value on this choice: research shows that nearly two-thirds of mid-size employers (those with 50 to 500 employees) would be willing to switch

payers for a premium reduction of 10 percent or less.²⁹ This raises the question of how much product variation is truly needed and if there is room to preserve choice while simplifying the administration that supports this variation.

From an administrative perspective, there are three potential benefits of modularized product design:

1. Enterprise benefits that simplify the suite of contracts between payers and providers, thereby reducing the manual entry of the customized product design agreed upon with each customer
2. Ability to deploy digital marketplaces that permit rapid updates in pricing, given the limited option set (compared to the current process of rerunning complex models to provide the customer with an updated price)
3. More intuitive customer engagement tools that nudge customers to select the best option at the moment of the decision given simplified underlying rules engines

A seismic intervention (for example, an aggregator site that publishes every payer's products and rates online, such as Kayak) that incentivizes the modularization of product design could deliver substantial administrative spending savings.

Adopt globally capitated payment models for segments of the care delivery system

Analogous to moving from cost-per-impression to pay-per-click for online advertising

The US healthcare system largely employs a fee-for-service payment model. A globally capitated model for certain segments (for example, populations like Medicare or illnesses like end-stage renal disease) could eliminate service-based payments from payers to providers. Instead, providers may receive a capped or fixed amount per patient for delivering a predetermined set of healthcare services, such as \$500 per patient per month.³⁰ The goal of these

models is to pay providers based on value versus on a per-service basis, as well as to ensure payers and providers are collaboratively taking on risk to support patient outcomes. When in these models, providers are more likely to implement certain initiatives that simplify administration, such as triage call centers (55 percent of providers who participate in these payment models versus 31 percent of providers who remain in fee-for-service payment models) and remote patient monitoring (49 percent versus 30 percent).³¹ However, adopting globally capitated payment models will likely not automatically reduce administrative spending. For example, in our experience, providers such as integrated delivery networks using these payment models have captured none or as little as about a third of expected administrative savings. Some reasons for this result may include healthcare regulations that require additional administrative spending in these models (for example, risk coding in Medicare Advantage) or the transfer of certain necessary administrative processes to the provider, such as PA for new standards of care.

While the administrative spending savings may be limited, we acknowledge that the primary financial benefit for globally capitated payment models is medical cost savings (not in the scope of this report). Still, if some of the interventions discussed in the previous chapters, such as AI-enabled PA, were implemented, the potential for administrative spending savings could increase. Further, though potentially limited, the administrative spending savings could fund the provider's transition to these payment models.

Finally, of the seismic interventions in this chapter, this is the least likely to gain traction in the near term. As of June 2020, less than three percent of payments were fully capitated.³² In addition, smaller providers may lack the ability or resources to invest in the capabilities that capitation might require, such as population health management tools, which could further slow adoption.

- ¹ We acknowledge that these partnerships should be structured and carried out consistently with all applicable laws and regulations governing competition.
- ² There is approximately a \$50 billion overlap in savings between seismic and within/between interventions identified in earlier chapters.
- ³ CAQH Index, "2020 CAQH Index: Closing the gap: The industry continues to improve, but opportunities for automation remain," Council for Affordable Quality Healthcare, 2021, caqh.org.
- ⁴ Transaction costs for payment through ACHs are \$0.08 per claim for private payers, compared to \$0.57 for manual payments; similarly, processing payments through ACH costs \$1.19 for providers compared to \$3.18 for manual payments.
- ⁵ CAQH Index, "2020 CAQH Index: Closing the gap: The industry continues to improve, but opportunities for automation remain," Council for Affordable Quality Healthcare, 2021, caqh.org.
- ⁶ ACH Fraud Report, "As payment card security rises, ACH fraud grows," Marqeta, 2020, marqeta.com.
- ⁷ CAQH Index, "2020 CAQH Index: Closing the gap: The industry continues to improve, but opportunities for automation remain," Council for Affordable Quality Healthcare, 2021, caqh.org.
- ⁸ "Health Information Exchange," Centers for Medicare & Medicaid Services, accessed October 15, 2021, medicaid.gov.
- ⁹ "Trusted Exchange Framework and Common Agreement," Office of the National Coordinator for Health Information Technology, last reviewed October 7, 2021, healthit.gov.
- ¹⁰ "United States Core Data for Interoperability (USCDI)," Office of the National Coordinator for Health Information Technology, accessed October 15, 2021, healthit.gov.
- ¹¹ Aaron Young et al., "FSMB census of licensed physicians in the United States, 2018," *Journal of Medical Regulation*, 2019, Volume 105, Number 2, pp. 7–23, fsmb.org.
- ¹² Donnie Bell and Mitchell Katz, "Modernize medical licensing, and credentialing, too—lessons from the COVID-19 pandemic," *JAMA Internal Medicine*, January 2021, Volume 181, Number 3, pp. 312–5, jamanetwork.com.
- ¹³ *Health Affairs Blog*, "Doctors without state borders: Practicing across state lines," blog entry by Bob Kocher, February 18, 2014, healthaffairs.org.
- ¹⁴ "About physician licensure: How physicians gain licenses to practice medicine," Federation of State Medical Boards, December 11, 2020, fsmb.org.
- ¹⁵ "Who is USMLE?," United States Medical Licensing Examination, 2021, usmle.org.
- ¹⁶ Kathleen Gaines, "What are nursing compact states?," Full Beaker, July 7, 2021, nurse.org.
- ¹⁷ "A faster pathway to physician licensure," Interstate Medical Licensure Compact, 2021, imlcc.org.
- ¹⁸ "About physician licensure: How physicians gain licenses to practice medicine," Federation of State Medical Boards, December 11, 2020, fsmb.org.
- ¹⁹ George Moseley III, "The U.S. health care non-system, 1908-2008," *Virtual Mentor*, 2008, Volume 10, Number 5, pp. 324–31, journalofethics.ama-assn.org.
- ²⁰ We defined commercial payer as those with employer-based coverage or non-group coverage.
- ²¹ Health Insurance Coverage of the Total Population, Kaiser Family Foundation, 2019, kff.org.
- ²² The triple aim is defined as improving care, improving population health, and reducing costs per capita; see "Triple aim for populations," Institute for Healthcare Improvement, 2021, ihi.org.
- ²³ Gail Wilensky, "The need to simplify measuring quality in health care," *Journal of the American Medical Association*, June 19, 2018, Volume 319, Number 23, pp. 2369–70, jamanetwork.com.
- ²⁴ Lawrence Casalino et al., "US physician practices spend more than \$15.4 billion annually to report quality measures," *Health Affairs*, March 2016, Volume 35, Number 3, healthaffairs.org.
- ²⁵ "Meaningful measures 2.0: Moving from measure reduction to modernization," Centers for Medicare & Medicaid Services, last modified March 31, 2021, cms.gov.
- ²⁶ To meet data submission requirements and data completeness criteria, physicians must report at least six measures or one specialty measure set and do so for each one for at least 70 percent of applicable patients. In addition to the six-measure requirement, groups of 16 or more eligible clinicians that meet a case minimum of at least 200 cases are subject to the 30-day all-cause hospital readmission measure. This measure is automatically calculated using claims data and is counted in addition to the quality reporting requirement.
- ²⁷ "AHIP, CMS, and NQF partner to promote measure alignment and burden reduction," Core Quality Measure Collaborative, May 12, 2021, qualityforum.org.
- ²⁸ "Part C and D performance data," Centers for Medicare & Medicaid Services, last modified September 13, 2021, cms.gov.
- ²⁹ McKinsey Broker Health Benefits Survey, 2018.
- ³⁰ We acknowledge that there may still be fee-for-service-based transaction costs for billing between the capitated provider and other providers such as post-acute facilities and laboratories.
- ³¹ "Premier Inc. survey: Clinically integrated networks in alternative payment models expanded value-based care capabilities to manage COVID-19 surge," Premier, May 13, 2020, premierinc.com.
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CHAPTER 9

How to catalyze change

Why has the US healthcare system not yet captured the \$265 billion in annual savings from known interventions identified in this report? The answer is different for “within” and “between” versus “seismic” interventions. For the first two types of interventions, the major barriers are at the organization level. These include the need for healthcare organizations to manage labor displacement in an industry that is a driver of US workforce growth and a lack of prioritization from industry leaders on administrative simplification. Organizations that have been successful in addressing these issues prioritize administrative simplification as a strategic initiative, commit to transformational change versus incremental steps, engage the broader partnership ecosystem for the right capabilities and investments, and disproportionately allocate resources to the underlying drivers of productivity, such as technology and talent. Seismic interventions, on the other hand, have not yet been adopted fully because of a lack of motivation to innovate at the organization level and therefore require stakeholders to take on industry-level roles, such as setting top-down guidelines for action (for example, interoperability frameworks); creating public–private partnerships; and collaborating with third parties, such as foundations, to research facts to galvanize action.

In chapters 3 to 7 of this report, we identified \$210 billion in savings from “within” and “between” interventions in five functional focus areas. In chapter 8, we identified \$105 billion from “seismic” interventions. Since many of these seismic interventions can partially replace within and between interventions, we found total savings of \$265 billion, or 11 percent of total administrative spending, after we accounted for overlap. This represents *where* the opportunity is in administrative spending today and *what we need to do* to get there (see Exhibit 9.1 for approximately 30 within and between interventions).

Yet, it would be natural to ask *why* the opportunity has not yet been realized and *how* to bring the interventions to fruition. The purpose of our analytical framework was to provide a roadmap for stakeholder groups to capture the opportunity; in this chapter, we will outline the *why* but focus on the *how* for each type of intervention.

Catalyzing “within” and “between” interventions

The opportunity and interventions identified in this report are not new. At the same time, however, little has been realized in the US healthcare system in a scaled and sustained way. Based on our firsthand experience, as well as input from many industry experts, some of the main challenges include the need to manage labor displacement in an industry that is a driver of US workforce growth and a lack of prioritization of administrative simplification by healthcare leaders.

Reviewing a number of high-performing healthcare organizations, we identified four common principles to overcome these challenges. While these principles are not necessarily new, they are often overlooked, resulting in failed attempts. Ensuring these are in place up front and committing to them as an organization is

critical to deliver the administrative spending savings from within and between interventions.

Make it a strategic priority: The organizations that have demonstrated success at administrative simplification make it clear at the highest level that the efforts are a strategic priority. This transforms the dynamic from a cost-cutting exercise to a major productivity initiative underpinning other organizational priorities such as growth, agility, innovation, and resilience. Research has shown that organizations that prioritize industry-leading productivity programs were twice as likely to be in the top quintile of their peers, as measured by economic profit.^{1,2}

Commit to transformational change: The organizations that conduct these bold moves create programs that are transformations, not one-off initiatives.³ To be successful in these transformational programs requires substantially more effort and planning than for discrete projects (for example, completing a full-potential analysis to set ambitious targets, instilling rigorous performance management, focusing on change management, pursuing systematic, multilever change). An analysis of more than 80 large-scale transformations of public companies showed that organizations that are comprehensive in this way were correlated with top-quartile total-return-to-shareholder gains.^{4,5}

Engage the broader partnership ecosystem: Administrative simplification benefits from partnerships. The rise of healthcare service technology (HST) companies and a deepening entry of technology giants into healthcare has created a broader partnership ecosystem, where newer technologies, such as cloud services, analytics, or member engagement, have been an enabler of growth.^{6,7} These HST companies reduce the scale requirement for a healthcare organization to

simplify administrative functions. Capability-driven partnerships have become another avenue for two or more organizations to overcome the economies-of-scale hurdle on specific strategic capabilities (for example, joint ventures between payers on claims adjudication platforms).⁸

Allocate resources disproportionately:

In our experience, capturing administrative savings requires an up-front,

one-time investment, generally 0.7 to 1.0 times the annual run-rate savings. The total investment can be substantial and may require commitment and financial prudence. It has multiple components. Part of it will be capital, as organizations invest in core technology or large-scale partnerships to pursue scale benefits (for example, investing in enterprise-level core administration platforms that allow seamless data processing across

Exhibit 9.1

Identified “within” and “between” interventions across functional focus areas

Functional focus area	“Within” interventions	“Between” interventions
Financial transactions ecosystem	<ul style="list-style-type: none"> • Simplify products offered • Streamline claims submission and communication process • Automate adjudication • Clarify Explanation of Benefits • Sunset old prior authorizations • Prescreen prior authorizations using digital support • Increase proportion of automated prior authorizations 	<ul style="list-style-type: none"> • Improve data management and coordination • Improve coordination and clarity on claims-related communications • Streamline claims payment tracking and recovery process • Align incentives between payer and provider through risk-sharing models • Align jointly on prior authorization criteria • Conduct targeted “gold carding”
Industry-agnostic corporate functions	<ul style="list-style-type: none"> • Promote operational excellence using traditional levers • Build for “functions of the future” 	
Industry-specific operational functions	<ul style="list-style-type: none"> • Promote operational excellence using traditional levers • Build smart services • Empower a function through foundational data investments 	
Customer and patient services	<ul style="list-style-type: none"> • Reduce transaction volume through proactive issue resolution and interface improvements • Improve handle time and issue resolution via artificial intelligence • Outsource to highly skilled vendors 	<ul style="list-style-type: none"> • Build strategic payer-provider platforms to reduce demand
Administrative clinical support functions	<ul style="list-style-type: none"> • Digitalize manual nursing management administrative activities • Enable management of larger spans • Digitalize and automate case and disease management processes • Integrate suite of tools and solutions • Improve operational discipline and ensure “top of license” practices 	

Source: McKinsey analysis

claims, care management, enrollment, billing). Another component is the need to attract varying kinds of talent. Change may depend on giving the right people the space to try new approaches. Many of these interventions could benefit from skills in advanced analytics and new technologies (for example, machine learning, cloud computing, natural language processing). In addition, people who are able to translate between technical and business teams and support a unified goal will be needed. Finally, operational leaders in the core business that understand and adopt the digital and analytical capabilities could be helpful. This new talent pool can be built both through hiring and through reskilling the current workforce. Given the amount of needed talent, organizations will likely need to do both.

Catalyzing “seismic” interventions

The non-exhaustive set of potential seismic interventions we outlined in chapter 8 relies on collaboration across public and private stakeholder groups, including individual consumers. The fact that this collaboration is likely needed leads to an important observation: these seismic interventions may require industry-level action since organization-level actions alone are not proving effective. By applying a framework on how to enable disruptive innovation in these types of situations, we could identify the underlying gap for each of the proposed seismic interventions, including the ideal stakeholder group (private or public sector) to carry out the right mechanism (for example, technology platform, operational alignment, payment design).⁹ We started by examining the five conditions for innovation. They fall into two categories:

Ability to innovate:

1. **Ability to experiment:** Existence of experimental infrastructure to test and validate new innovations

2. **Ability to sunset outdated infrastructure:** Latitude and market mechanisms to remove outdated technology and business models

Motivation to innovate:

3. **Existence of feedback loop:** Feedback loops between customers and organizations to motivate investment into and adoption of the right innovations
4. **Existence of incentives for product or service improvement:** Financial or non-financial motivation to improve performance of the innovation
5. **Existence of budget constraints for end users:** Budgetary constraints on the end user of innovation to force right prioritization

We reviewed each of the seismic interventions against these conditions (Exhibit 9.2). In general, implementation of seismic interventions is not held back by the ability to innovate. In our example seismic interventions, there were clear pockets of innovation and experimentation across all (for example, standardization of nursing licensure or creation of a unified Medicare medical policy), though with varying degrees of completion. The more common hurdle was the motivation to innovate. In general, the financial pressure to act is not apparent at the organization level (for example, limited incentive to use a centralized claims clearinghouse). Therefore, given the outsize impact these seismic interventions could create, stakeholder groups across the healthcare spectrum may need to play specific role at an industry level to create the right motivations:

- **Government could set a framework:** Federal and state governments could consider setting the guardrails within which healthcare organizations could operate in areas where natural market competition has not led to optimal behaviors. The interoperability rules that the Centers for Medicare & Medicaid (CMS) have set are an example;

Exhibit 9.2

Seismic interventions have not yet occurred because organizations lack the motivation to innovate

■ Condition already met ■ Path forward to meet condition already underway ■ Potential action needed to meet condition

Five conditions for breakthrough innovation	Seismic interventions						
	Technology platforms		Operational alignment			Payment design	
	Adopt centralized automated claims clearinghouse	Prioritize high-value interoperability use cases	Standardize physician licensure	Standardize medical policies	Streamline quality reporting	Modularize benefits	Adopt globally-capitated payment models
Is there <i>ability</i> to innovate?							
Ability to experiment Existence of thoughtful methodology, approach, and funding for “testing” the idea	Met: Automated clearinghouses have already been shown to work in banking, and 70%+ of healthcare payments already are submitted through the National Automated Clearing House Association (NACHA)	Met: Multiple technology initiatives have been launched at the US healthcare system level to tackle this (eg, FHIR, interoperability rules)	Met: Nursing licensure compact, which is signed by almost 35 states and allows nurses to work across state lines, has already proven this model can be used in the United States	Met: Medicare is able to influence the market in a way that promotes standardized policies	Met: Well-recognized problem; CMS has already launched multiple initiatives to simplify quality reporting	Met: Benefits of standardized offerings in both Individual Market and Medicare Advantage are already visible	Met: Providers already operating in a value-based payment paradigm
Ability to sunset outdated infrastructure Capacity to freely remove outdated technology and business models	Path forward: Long-tail of local/regional claims processing warehouses may need to integrate their workflow into single ACH	Path forward: Agreement on which handful of existing initiatives will align with high-value use cases (eg, patient-centered health-care database) and which to sunset	Path forward: Ability to remove state-specific licensures in nursing compact already proven	Met: Medical policies are already regularly updated as new innovations and standards of care emerge	Met: Providers can focus on narrower set of prioritized metrics; payers will potentially have to replace quality metrics in contract arrangements with providers	Path forward: Review all contracts with a given provider and determine the “least common denominator” version that could satisfy many customers; integrate new, simpler benefit design into core functions (eg, underwriting, sales, marketing)	Potential action needed: While there is a shift to VBC models generally, most of this is still built on top of FFS foundation with only 3% fully capitated; broader action would be needed to fully shift infrastructure (eg, contracts, payment platforms) to global capitated
Is there <i>motivation</i> to innovate?							
Existence of feedback loop Building strong feedback loops between stakeholder groups to motivate investment into and adoption of the right innovations	Met: Feedback loops between payer and customers (members and providers) already exist, and channel will continue to exist	Potential action needed: Convene a group of stakeholders to discuss and align on high-value, system-level use cases that help prioritize interoperability-related technology initiatives	Potential action needed: Launch a process that solicits states’ inputs on what the federal licensure should look like	Potential action needed: Create an ongoing, diverse commission to review and update medical policies	Met: CMS already engages with provider stakeholders (eg, AMA, AHIP) to solicit feedback on which quality metrics to keep or remove	Path forward: Customers have suggested willingness to switch carriers for reduced premiums	Potential action needed: Though there is momentum to shift to VBC, there are constraints (eg, lack of opportunity for providers, payers lacking data on delegated risk); need to incorporate these issues as the intervention is launched
Existence of incentives for product or service improvement Motivation to improve performance (financial or non-financial)	Potential action needed: Create financial incentives for organizations that opt out of ACH	Path forward: Use case alignment will allow organizations to capture a greater ROI on technology investments as well as allow vendors to better hone their products/service offerings	Potential action needed: Create a commission with representation from states and physicians that monitors impact of standardized licensure and recommends changes if needed	Potential action needed: Payers will have to find other ways to differentiate than medical policies (eg, product design, pricing)	Potential action needed: Payers and providers are better able to differentiate performance in VBC settings if there is a standardized, focused list of metrics to reach	Met: Payers will be pushed to develop simpler and more compelling digital tools as part of sales process with customers	Met: Revenue in these models is predetermined on a per person basis, creating incentives to provide better products/services for payers to increase member attraction and retention
Existence of budget constraints for end users Budgetary restrictions that will force prioritization of the right actions	Potential action needed: Financial incentives for organizations that opt into ACH could create competitive advantages	Met: Payers and providers are already spending substantially on individual technology projects related to interoperability; alignment on use cases could remove unnecessary spending	Potential action needed: States may need offset from reduction in licensing revenues (eg, quantifying benefits of increased physician access within their areas)	Potential action needed: Currently no budget incentive for a payer to standardize medical policies; payers would need financial incentives to follow national standards	Met: Physicians already spend substantial time and operating expenses to meet quality reporting requirements	Path forward: Ongoing price pressures in Commercial/fully-insured segments are likely to create more impetus for finding ways to reduce payer expenses	Met: Global capitated models do provide incentives for organizations to improve productivity, including administrative spending, given shift in profit economics

Source: Lawrence Casalino et al., “US physician practices spend more than \$15.4 billion annually to report quality measures,” *Health Affairs*, March 2016, Volume 35, Number 3, healthaffairs.org; Andis Robeznieks, “AMA to CMS: Work to simplify Quality Payment Program regulations,” American Medical Association, August 21, 2017, ama-assn.org; Gail Wilensky, “The need to simplify measuring quality in health care,” *Journal of the American Medical Association*, June 19, 2018, Volume 319, Number 23, pp. 2369–70, jamanetwork.com

it has defined both what it expects to see (for example, payers and providers to build application programming interfaces (APIs) to readily share data) and timelines for realization.¹⁰ But the agency has left it up to individual organizations to determine how to get there.

- **Investors can prove ideas with pilots:** In healthcare, there has been a recent boom in investment from institutional investors (private equity, venture capital, and hedge funds).¹¹ This type of funding allows for rapid testing, scaling, and evolution of innovation in healthcare in a way that the public sector could not replicate. Creating public–private partnerships could infuse the benefits of private investing into seismic interventions that may be driven by the public sector. For example, instead of each state building a health information exchange (HIE) by itself, a public–private partnership in a pilot state could prove the model and then disseminate the technology platform to other states for rapid scale-up. This may lessen the overall public sector budget burden while also incentivizing private sector investment.

- **Third parties can provide objective fact gathering and analyses:** Given the benefits for collaboration across stakeholder groups, neutral and objective third parties such as foundations or bipartisan groups can be the arbitrators of facts. Whether it is benchmarking to highlight healthcare organizations that are leading in administrative simplification or funding small-scale experiments, such as a randomized control trial of a small group of private payers or hospitals to test what conditions may be necessary for administrative savings, the publication of these organization-level data could galvanize action among other healthcare organizations.

While the goal of addressing unnecessary administrative spending in US healthcare has seemed elusive, this report aims to create a roadmap that: (1) identifies a concrete set of known interventions (within, between, and seismic) against a set of functional focus areas, (2) breaks down *how* these savings could be achieved within the US healthcare system, and (3) offers a framework for what roles different stakeholder groups could play to deliver the opportunity.

¹ Martin Hirt, "How to create a real hockey stick strategy," February 25, 2018, McKinsey.com.

² Chris Bradley, Martin Hirt, and Sven Smit, "Strategy to beat the odds," February 2018, McKinsey.com.

³ "The path to true transformation," October 28, 2020, McKinsey.com.

⁴ "The path to true transformation," October 28, 2020, McKinsey.com.

⁵ Kevin Laczkowski, Tao Tan, and Matthias Winter, "The numbers behind successful transformations," October 2019, McKinsey.com.

⁶ Shubham Singhal, Basel Kayyali, Rob Levin, and Zachary Greenberg, "The next wave of healthcare innovation: The evolution of ecosystems," June 23, 2020, McKinsey.com.

⁷ Greg Gilbert, Jay Krishnan, and Drew Ungerman, "What payers and providers can learn from successful cloud transformations in other industries," June 28, 2021, McKinsey.com.

⁸ We acknowledge that these partnerships should be structured and carried out consistently with all applicable laws and regulations governing competition.

⁹ Nikhil Sahni, Maxwell Wessel, and Clayton Christensen, "Unleashing breakthrough innovation in government," *Stanford Social Innovation Review*, Summer 2013, ssir.org.

¹⁰ Calder Lynch, "Implementation of the CMS Interoperability and Patient Access Final Rule and Compliance with the ONC 21st Century Cures Act Final Rule," Centers for Medicare & Medicaid Services, August 14, 2020, medicaid.gov.

¹¹ "Venture investments in digital health during the first half of 2021 have already surpassed funding raised in all of 2020 and is the largest amount raised in a single year since 2010," from Heather Landi, "Digital health dollars hit \$15B high driven by telehealth investment in 2021," *Fierce Healthcare*, July 19, 2021, fiercehealthcare.com.



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